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First Steps Toward Successful Communication About Sexual Health Between Adolescents and Parents in Mexico

Lourdes Campero,[1] Dilys Walker,[1] Mariel Rouvier,[1] and Erika Atienzo[1]

Abstract

In this article reporting on our qualitative study, we describe changes in parent–adolescent sexual health communication following an intervention for parents of 10th graders in Mexico. The intervention was aimed to sensitize and develop skills for appropriate parent–child communication about the prevention of sexually transmitted infections (STIs), unplanned pregnancy, and birth control, and focused on encouraging condom use with emergency contraception backup. We conducted 66 in-depth interviews with adolescents and parents after the intervention. Following the principals of grounded theory, we carried out inductive analysis to create codes and organize central themes. Our findings identify previously undefined critical steps or movements important for parent–child communication about sex. When parents are sensitized to the risks their adolescent children face, it is easier to initiate communication about prevention. These initial movements are essential to achieve substantive conversation, and must be considered in future strategies that aim to promote parent–adolescent communication about sexuality and the prevention of STIs and unplanned pregnancy.

Keywords

adolescents; communication, intergenerational; health education; HIV/AIDS; Mexico, Mexicans; pregnancy, avoidance; sexual health; sexually transmitted diseases

Lowering the rates of sexually transmitted infections (STIs) and reducing unplanned pregnancies in adolescents is a public health priority in Mexico (Pan American Health Organization, 2007). Thirty percent of Mexican adolescents (16 to 19 years old) have had a sexual relationship (Olaiz-Fernández et al., 2006). In one study on Mexican adolescent mothers, the authors reported that immediately postpartum, 22% of mothers stated that the pregnancy was unwanted (Nuñez-Urquiza, Hernández-Prado, García-Barrios, González, & Walker, 2003). Furthermore, in Mexico, the prevalence of herpes simplex type 2 has been reported at 21% among students in Morelos high schools (Gutierrez, Conde-González, Walker, & Bertozzi, 2007).

Internationally, educational programs aimed at adolescents that are taught as part of the regular curriculum or as extracurricular activities in schools have been the primary strategy for reducing adolescent STIs and unplanned pregnancies (Kirby, 2003). Nevertheless, conversations between adolescents and informed parents can also play an important role in promoting sexual prevention messages for adolescents (Swann, Bowe, McCormick, & Kosmin, 2003). In this context, the majority of current educational interventions that include parents' participation have been designed based on developed countries' experiences and evaluated from a primarily quantitative perspective.

These interventions have shown positive effects including increased frequency of communication between parents and their adolescent children; higher comfort levels when speaking on this topic; greater capacity to answer questions and be open to dialogue (DiIorio et al., 2006; Dittus, Miller, Kotchick, & Forehand, 2004; Klein et al., 2005; Lefkowitz, Sigman, & Kit-fong, 2000;

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O'Donnell et al., 2005); less desire to initiate sexual activity on the part of the adolescent (Blake, Simkin, Ledsky, Perkins, & Calabrese, 2001; Dancy, Crittenden, & Talashek, 2006; Lederman, Chan, & Roberts-Gray, 2004); increased condom use (DiIorio et al., 2006; Kirby et al., 2004); and decreased number of sexual partners or a reduction in the level of sexual activity (Lonczak, Abbott, Hawkins, Kosterman, & Catalano, 2002). However, as some study findings indicate, parent–child communication is not always easy or comfortable. Even though it has been shown that parents are concerned about the importance of providing information regarding changes during puberty (Thelus, Bondy, Wilkinson, & Forman, 2009), there are a variety of difficulties in initiating and maintaining a dialogue, particularly about sex, and especially when pregnancy and STI prevention is discussed. Common barriers include moral values, embarrassment, prejudices, and ignorance about the correct use of condoms and other contraceptive methods (Eastman, Corona, Ryan, Warsofsky, & Schuster, 2005; Jaccard, Dittus, & Gordon, 2000).

In Mexico, few educational programs exist that focus on sexual health and prevention of STIs and pregnancy, and that provide parents with information as well as strategies for communicating with their adolescent children. These programs mainly fall under the auspices of nongovernmental organizations such as the Mexican Institute for Investigation of Family and Population (IMIFAP) or the Mexican Foundation for Family Planning (MEXFAM). Although these programs are doubtlessly valuable, they are scarce and not always rigorously evaluated (Givaudan et al., 1994; Givaudan, Pick, & Proctor, 1997).

Although important differences among families in Mexico exist, strong family bonds in general are present and important. At the same time, there are significant challenges and barriers to open and early parent–adolescent communication about pregnancy prevention and sexual health (Módena & Mendoza, 2001; Villaseñor, 2008). For example, because Catholicism is the backdrop for many middle-class family values, sexuality is a moral issue (Amuchástegui, 2001) and abstinence is the cornerstone of sexual education (Pick, Givaudan, & Brown, 2000). Sharing concrete information about how to use contraceptive methods would imply recognizing the possibility of an adolescent actually being sexually active (Rouvier, Campero, Walker, & Caballero, in press).

From 2006 to 2008, researchers at the National Institute of Public Health (INSP) designed, implemented, and evaluated a randomized educational intervention for parents of high school–attending adolescents that emphasized improved communication between parents and their adolescent children, mainly about STIs and pregnancy prevention. The primary goal of this article is to document, from a qualitative perspective, that this intervention improved parent–adolescent sexual health communication. Our results focus on intermediate processes, collateral movements, and introspection among the participants that allowed us to identify valuable positive and important elements of the educational program. We also aimed to recognize the difficulties and potential advantages inherent in working with parents who are in the process of becoming educators about sex education and sexual health promotion for their adolescent children.

Description of the Intervention

The intervention was designed by the research team in accordance with social learning, planned behavior, and reasoned action theory. We also took into account sex education from a perspective of social gender construction and integrated basic elements of prevention-based programs, including either abstinence-based (those that promote the delay of the initiation of sexual activity) or safe-sex-based elements (those that promote safer sex by encouraging the use of condoms or other contraceptive methods). We also recognized adolescents' capacity to choose when and with whom to have sexual relations, as well as their basic individual autonomy in terms of sexual relations and their ability to negotiate the use of contraception (Pan American Health Organization, 2007).

The intervention consisted of four workshops (each 3 hours long) aimed at improving communication between parents and their adolescent children on subjects including how to begin a conversation, sexual health, skill development for correct condom use and, as a backup method, the correct use of emergency contraception (EC). In each school, a group of three previously trained field workers made up of psychologists, educators, and sociologists led the workshops. Their 15-hour training emphasized the goals, interactions, and attitudes we were interested in promoting. Following the training, each leader was confident and able to manage each workshop with consistent philosophy, approach, and content.

Each workshop consisted of (a) short group activities designed to develop awareness about the importance of parent–child communication concerning STIs and adolescent pregnancy prevention; (b) brief subject-specific presentations on adolescent self-esteem, the value of timely and appropriate parent–child communication, STIs, adolescent pregnancy, and the correct use of prevention methods; (c) access to prevention methods (condoms and EC); and (d) development of skills to assist in parent–child communication through dynamic interactive sessions using role play and group as well as paired activities. In the third and fourth sessions, the presenters used, as a central strategy of our methodology, a small, discrete "prevention pack" labeled "Tools for talking

with your adolescent." This prevention pack contained three condoms, an explanation of the necessary steps for its correct use, a dose of EC with a clear and precise explanation of how to take it, a short pamphlet with names of five common STIs (syphilis, gonorrhea, herpes, human papillomavirus, and HIV/AIDS), and a brief explanation of the symptoms and treatment for each. At the end of these sessions, parents were offered the prevention packs for a minimal charge to help offset their cost (approximately $1.25 U.S.).

As a fundamental element for acquiring and practicing new skills, the parents left each session with a homework assignment—a simple, gradual task they were to complete with their children. At the beginning of each session, the parents talked about their experiences with the homework. At all times, the emotions, opinions, values, and concerns of the parents were considered and respected. During each of the sessions, the leader supported parents who considered it necessary to promote abstinence before marriage with their children, but they also encouraged them to include clear and accurate information about prevention methods and their correct use.

Methods

This research was part of a larger qualitative–quantitative study, the objective of which was to develop and evaluate an educational intervention for parents of adolescents in 10th grade (15 and 16 year olds) from 22 public high schools (11 intervention and 11 control) throughout the state of Morelos, Mexico. In this article, we present the qualitative findings, based on 66 interviews with parents and adolescents.

Sample Selection

In the intervention schools, 588 parents participated in the workshops (corresponding to 19% of the students surveyed). The data presented here come from five of these schools (three in urban zones and two semirural ones), where a total of 305 parents participated. The selection of participants for the qualitative study was intentional. As part of the inclusion criteria for the adolescents and their parents, the researchers considered that the parents attended at least three out of the four workshops that comprised the educational intervention. From a baseline questionnaire conducted among students in all the schools, the researchers identified adolescents whose parents attended the workshops, some of whom were sexually active and others who were not. Following the last workshop, the researchers invited some of the eligible parents, with different participation rates, to join the qualitative study. Afterwards their adolescent children were invited to participate. The object was to conduct two interviews: the first one a few days after the last workshop, and the second 5 months later. In approximately 25% of the cases, only one interview was conducted. Because of this loss to followup, we invited additional parents to participate in the second round of interviews and included key elements from the first and second interview guides. We used saturation theory to develop criteria for limiting data collection. Once interviews became repetitive without additional value or without new content in our predetermined categories, we stopped collecting new data (Greene, 2000; Patton, 2002).

In the first stage, 33 interviews were conducted: 15 with adolescents (8 women and 7 men), and 18 with parents (12 mothers and 6 fathers). Four of the adolescents reported they were sexually active, though none of their parents were aware of this. In the second stage, we conducted 30 interviews, 16 with adolescents (8 women and 8 men) and 14 with parents (11 mothers and 3 fathers). Among the participating parents, the mean age was 42 years, and the majority were married or living with their partner (80%). Most parents had completed secondary school (66%), but only a third (28%) had completed high school. Among adolescents, the mean age was 15.2 years and the majority lived with both of their parents (87%).

Data Collection and Analysis

The interviews were semistructured and lasted an average of 45 minutes. The majority of the interviews were conducted in an empty classroom or some other quiet and private place in the school; a few were carried out in the participant's home. These interviews concentrated on parent–child communication, the presence or absence of prevention messages in such communication, as well as the difficulties and barriers to communicating on certain aspects of sexual health. They also explored the perceptions that parents and their children held about young people's sexuality, identification and risks of STIs and unplanned pregnancy, and knowledge and perceptions about condom and EC use. Based on these themes, the central emphasis was on changes in perception, attitudes, and/or conversation content generated by the intervention.

Using the basic elements of grounded theory, as described by Glaser and Strauss (1967) and by Strauss and Corbin (2003), in which codes or themes emerge from the narratives of the research participants, we followed an inductive analysis. First, we defined a typology of codes and definitions created from the interview guide and reconfirmed throughout the coding process. Then we organized the data by these emerging themes. For both parents and adolescents, and for both phases of the interviewing process, we generated the following families

of codes: (a) communication about sexuality, (b) sexual relations, (c) STIs, (d) adolescent pregnancy, (e) condoms, (f) emergency contraception, (g) contraception, and (h) school participation. In this article, we present those categories that represent positive changes or movements as an outcome of the intervention program. All data were processed using the NVivo computer software program (Richards, 1997).

All participants (parents and adolescents) signed a letter of consent containing the study's objectives, the expected degree of participation, a guarantee of confidentiality and anonymity of the data, and permission to record and transcribe the interviews. After we interviewed parents we asked for their consent to interview their adolescent child. Each adolescent had the right to accept or refuse being interviewed, and each was required to sign their own letter of consent to participate. This study was approved by the INSP Research and Ethics Committees.

Results

We describe the steps or movements toward effective communication about sexual health identified in the interviews with parents and their adolescent children that took place after they had participated in the educational intervention. These changes were evident in the testimonies from parents and adolescents that shed light on their perceptions, attitudes, and the actual content of their conversations.

Parent Acknowledgement of Risk and Introspection About Their Own Knowledge Gaps

At the start of the intervention, a few parents clearly recognized that their child could be at risk of contracting an STI or having an unplanned pregnancy. This was because most parents did not recognize when their child was sexually active or that he or she might soon become sexually active. Through the intervention, many parents began to see the risk inherent in not speaking to their children about these themes. Initially, many believed that speaking specifically about sex or contraception would encourage the adolescents to initiate sexual activity sooner. By the close of the workshops, this perception was modified for many:

> Father (F): Because, well, before this class [the workshop] I thought that the less we told kids about sex the better.
> Interviewer (I): And that idea has changed for you?
> F: Yes completely.

By the end of the intervention, some parents understood and expressed a new belief that it was necessary to speak with their children before it was too late to prevent an unplanned pregnancy or an STI. They also recognized their own personal gaps in knowledge that limited their ability to converse comfortably about the subject.

Information Transmission

One of the most important objectives of this intervention was to provide parents with up-to-date information about STIs, correct condom use, and EC, so they could feel comfortable transmitting this knowledge to their children. However, because of personal, cognitive, and cultural factors, the communication achieved about specific prevention messages was of varying quality and content. Even though the majority of parents did not completely realize this objective, it is worth presenting the diverse experiences reported by parents and their adolescent children that indicated movements in the right direction. Depending on the degree of advancement in these movements, we identified three groups of parents: those who made minimal advancement, those who made moderate advancement, and those who made significant advancement.

Minimal advancement. This group was comprised of parents of adolescent children who directly or indirectly took new, small steps to talk about prevention because of the workshops. For example, the parents were able to speak at least in general terms about the subject with their children, and the children appreciated that their parents were more informed. Even though this change appeared to be minimal with respect to our main objective, it is relevant to show that a dialogue about sexuality was initiated, even if it was only once and superficial, and that the children perceived that their parents had up-to-date information. This is a critical first, albeit insufficient, step toward meaningful communication.

Moderate advancement. In this second group, more important changes took place. The parents began to give their adolescent children some specific tips on prevention. In some cases, this occurred even though previously they had never discussed sexuality or sex. Other parents had previously spoken vaguely about it and were able to give new information with more specific prevention tips. Both parents and adolescents mentioned that prior to the intervention, on one or more occasions, they had spoken about HIV/AIDS, but never about other STIs. After the intervention, parents mentioned gonorrhea, syphilis, herpes, and human papillomavirus with greater clarity. These two last STIs were new to many parents; on several occasions the parents mentioned that they had not previously heard of them or paid much attention to the available information. After the intervention and with the support of the prevention pack, more appropriate and specific information was provided on these STIs:

Yes, we speak about the diseases, I have told them about human papilloma, that it doesn't have a cure, you can treat the symptoms. I have spoken to them about gonorrhea, all those diseases that are out there. . . . I say they must take care of themselves because any time they have sex without protection they can get infected with some of these diseases that I am telling them about . . . with the papers that they gave me back in the workshops [referring to information contained in the prevention pack], I gave them the bag and I explained it to them. (mother)

In this group were parents who, after the workshops, mentioned condom use specifically to their children:

Mother (M): Well, since his sister gave them [the condoms] to him, I didn't say anything more than, "Son, what are you going to use them for? You are both very young," and he says, "Aw, Mom! They aren't for me to use, they are for throwing around as balloons, because that's what we do when we are goofing around at parties. Do you think I'm going to use them? Not yet." That is what he said to me.
I: And now after the workshop have you spoken to him a bit more about the condom, how to use it?
M: Yes! My husband asked him if he knew how to use it and [the son] told him, "I have never put one on, but it's like this, it is used this way" [imitating some hand gestures made by the son]. [My husband asked], And who told you that?" and [the son] said, "In the school."

Even though some parents and/or adolescents knew what EC was, except in one case, this subject had never been discussed between parents and adolescents before the intervention. EC was a more difficult prevention method than condoms to incorporate into parent–child communication. Nevertheless, in this group we could identify some parents who managed to provide some important information on this subject:

I: Have you spoken about emergency contraceptive pills with [adolescent daughter]?
M: No, I hadn't spoken with her, before the workshop.
I: What did you say to her after the workshop?
M: Well, it seemed like a very good idea to her. She said, "Well, yes there is a solution for an unplanned pregnancy but it doesn't protect me from diseases." I said then that the best thing for her is the condom, the emergency pill is for when the condom breaks, that is how I explained it . . . but taking them out of the package and saying, "Look, these are the pills," no.

Significant advancement. In this last group, the movement was more pronounced. The information the parents offered their adolescent children was more complete about STIs, correct condom use, and EC. Although these parents were not the only ones who used the prevention pack, it was evident by the testimonies collected that this group of parents learned about and took more thorough advantage of the contents:

I: Have you explained to him how to use it, have you opened one [a condom]?
M: Yes, one day we sat down with him and the bag they gave us [the prevention pack] that had a bunch of condoms and a package of emergency pills. We explained carefully each one to him. There was a pamphlet, and we asked him to read it even after all the explanation that we gave him, and that if he had any questions, to ask us.
I: Did you open a condom together?
M: We did open the package, the condom, together. What [is] more, he said to us, "No, because I know how to use it," and we told him to open it. Then he couldn't open it with his hands and so he was going to open it with his teeth and we told him, "No, they say that you must never open it with your teeth; it must always be with your hands, and you must remove it carefully, you must press the tip of the condom and then begin to put it on the penis, and afterwards hold the bottom tightly and throw it in the trash. It cannot be used more than once."

The adolescents in this parent group also reported more detailed conversations with their parents:

I: For example, in the bag [the prevention pack], did you see that it came with condoms?
Daughter (D): Yes, she taught me how to use them. She opened some of them, and she taught me how to put them on.
I: She taught you the steps of how to put on a condom?
D: Yes.
I: Do you think that you learned how to use a condom?
D: Yes, I think so.

This adolescent daughter reported having had sexual relations, but her parents did not know this. She also stated that she had used condoms.

In this group, we interviewed parents who were able to speak to their adolescent child for the first time about EC, and managed to provide specifics concerning its appropriate use:

I: Did your mother buy the bag [prevention pack]?
Adolescent (A): Yes.
I: Did she show it to you?
A: Yes.
I: What did she tell you?
A: She said what the pills are for, how they are used, like when they should be taken.
I: Have you both spoken about this already? Have you ever heard her speak of EC before the workshop?
A: No, of that no.
I: You tell me that your mother told you how they are taken, and she showed you the pamphlet. Have you read it?
A: Yes.
I: What do you think?
A: Well, I think that yes, it is very useful. Like if the condom breaks and some sperm get out, it could save you from an unplanned pregnancy.

Attitudes About Communication

Fear and embarrassment make it difficult to begin dialogue on taboo subjects such as healthy sexuality and STI and pregnancy prevention. For this reason, in the workshops we tried to modify attitudes by offering information and skill development so the parents could feel more self-confident, and consequently could overcome these barriers to conversation. In the parents' narratives, it is clear that once the parents felt they had the tools to address the subject with their adolescent children, they were more confident, and more disposed to broach the subject of sexual health. It was possible to identify among these parents better listening skills, greater openness to discussion, and a willingness to ask and answer questions. For example, one adolescent told us how her mother opened up for the first time and responded to her doubts:

D: She gave me the pamphlet and afterwards we began to talk, and I had a doubt so I asked her. I wondered, if you put on a condom, he penetrates you, does the condom come out? . . . Does he take it off or does it stay inside? . . . And if he wants to penetrate you again, is it with another [condom]?—because I didn't know.
I: Did you ask your mom this?
D: Yes, my mom.
I: Did she answer you?
D: Yes.
I: Did it embarrass her? How did she look to you?
D: Different, as she responded to me, she seemed different.

This adolescent daughter also reported that she had had sexual relations, but her mother did not know it.

We also identified that these parents had more tolerance, had a greater capacity to respond with clear arguments, had debates about magazine articles or TV programs, and even made jokes. It is evident that when adolescents saw a more open, confident attitude in their parents, they found it easier to speak and even attempt to joke with their parents:

> They told us [at the workshop] that they break [the condoms] because the person doesn't know how to use them. Now, if they do not know how to use it, well, sure they break, I told him, but if someone opens them well, [there is no problem]. . . . So we took one out and we unrolled it and then he [the son] inflated it and began to play with me. (mother)

At the same time, once the parent–child dialogue was initiated, the adolescent children felt more confident to ask their parents to reiterate explanations:

M: Even one day she asked me, "Hey Mom, how did you say that a condom is used?" I said, "Aw, you forgot." We were walking and chatting and I said, "I told you how, don't you remember?" So I told her again. I said, "I remember better than you."
I: You repeated the explanation to her of how to use it?
M: Yeah.
I: But without a condom?
M: Yes, without a condom, but I took my finger and said, "Look, this is how you pull it down." And it wasn't a big deal for me [laughs].

Simply opening the lines of communication and initiating dialogue of this type, independent of potentially conflicting ideologies or opinions, favored a more fluid interchange of ideas and was in itself advantageous for the parent–child relationship.

Gender Roles

As a result of the intervention, we noted changes in certain ingrained gender roles and perceptions in the family structure. This was particularly true in families with a strong traditional structure in which family members were not accustomed to speak about these subjects, and in which women were generally not informed on subjects concerning sexuality, sexual health, or STI and pregnancy prevention. For example, in rural communities, where the husbands had significant social control over their wives

and children, the intervention sensitized them about the importance of speaking about this subject within the family. The husbands began to accept their wives speaking about these subjects with their daughters:

> So he [husband] didn't allow this, didn't accept it, but because of the workshops—thank God he came to all of them—and it helped me a lot because now he says to me, "You talk with them [daughters]." . . . Now he allows me to. Before, no, I wasn't free to talk with my daughters because he got mad, he got angry, said that I was giving them too much freedom and that I knew everything about them and I was covering up for them. I told him that, "No, that's not it. All I do is listen to what they say, what they want to know," but he didn't understand. But now he says, "Talk with your daughters, speak with them." I say that they [the daughters] are both of ours. "Well," he says, "Yes, but I cannot [talk to them]." (mother)

In homes where mothers were the primary communicators with their children, particularly adolescent daughters, we found another change that represented an important movement toward healthy communication. Here, contrary to the situation related above, the mothers asked the fathers to speak with their sons and daughters:

> I told him [husband], "I'd like it if you went, even if it was only one time [to the workshops]."He said, "Yes, but I cannot because of my work. But it's good that you go because you are in charge of everything" [she laughs] . . . . But my husband agreed to teach them how to use a condom, and he hasn't done it. I told him that I wanted him to teach the girls how to use them. (mother)

For some adolescents, speaking with their fathers about sexual health was a new and somewhat confusing experience. Some of the adolescent girls stated that their fathers had recently approached them to speak about these subjects:

> I: So you tell me that you were able speak with your father. Great.
> D: Yes.
> I: What were you able to speak with your father about?
> D: Well no, we didn't speak about specific things, but well, yes, he'll make some comments to me, but we didn't sit down and talk . . . and he hasn't actually spoken with me, but makes some passing remarks.
> I: Have you noticed some change? That your father has started to speak about this, is that a change?
> D: Well, yes [laughs].
> I: And you—what do you think has changed for your father to speak with you?
> D: Well, I do not know [laughs]. . . . I think my mom said something to him. I do not know, but that's what I think.

For many in the society, it is considered important that men are informed about topics of sexual health and prevention, but not women, and particularly not adolescent girls. This is because of the cultural acceptance that adolescent boys might initiate sexual relations, but not girls. At the beginning of this study, a large group of parents shared the belief that only men, and not women—especially not adolescent women—should be informed about sexual health. To achieve a change in this belief was particularly valuable in a society in which, oftentimes, women are shortchanged when it comes to receiving prevention information. Some mothers actively recognized the importance of this information for the adolescent girls, as well as the adolescent boys:

> Yes, yes I showed her [daughter] the pamphlets that they gave us. I showed her the condoms. I showed her the pills. I said to her, "Look, I want you to read this about condoms because it is important. It isn't something just for men." I told her that I also didn't know about it, and that it helped me also, so yes, I spoke to her, but after the workshops. (mother)

This narrative illustrates a mother recognizing the fact that her daughter needed information, and then she actually moved toward transmitting that information to her daughter.

Dialogue Between Parents About Sex Education for Their Children

Aside from alterations in the roles between parents regarding whose job it was to discuss sexual health with their children, we also found that the information provided in the workshops offered the first opportunity for many parents to speak between themselves about the sexual health of their children. In some cases, parents were able to better coordinate their roles in the conversations with their children:

> At the last workshop I said to her [wife], "Well, I've already spoken twice with my sons, and you, that is, we've spoken to them [sons]," and she

> backed up what I was saying, but I said to her, "Now I'm going to be there and it's going to be the other way around, that is, you're going to talk with them and I'm going to back up what you say." . . . I said to her, "Now you're going to have to do it because you must sometimes speak with my sons," and I also said to her, "Someday, I'll have to speak with my daughter, as well." (father)

One adolescent boy also referred to a coordinated effort between his parents when speaking with him:

> I: Have you ever opened a condom together?
> Son (S): Yes.
> I: With whom, your dad or your mom?
> S: With both.
> I: Was this after the workshops?
> S: Yes, after the workshops.

Sometimes it was enough when only one of the parents attended the workshop, because this acted as a catalyst for dialogue between parents to discuss the issue and agree on the information to transmit to the children:

> I: Do you think that your husband supports you when you speak about these subjects with [daughter]?
> M: Yes, yes, because in the workshop, they gave us homework to teach her how to use a condom or have her show us how to use one, and I asked him [husband], "What do you think about this?" [He said], "It's okay because if her boyfriend doesn't know how to use it and she doesn't know how to use it, what will they do?"

This unexpected yet critical result underscored the importance of dialogue between parents to come to a consensus about both the importance of this type of communication and about the specific content of such conversations prior to actually initiating dialogue with the adolescent about sexual health.

Secondary Effect of the Intervention: Information Transmitted to Other Adolescents, Other Adults, and Between Adolescents

Some parents, after recognizing the importance of sexual health knowledge for their own adolescents, wanted to also share this information with other members of their extended family or community. For example, some parents expressed that after the workshops, they decided to speak with other children (adolescents and nonadolescents), with nieces and nephews, and even boyfriends and girlfriends or their children's friends:

> There is a boy from school who visits her [daughter] a lot. Probably they are already dating. . . . I talked about this [sexuality] with the boy, because there is a lot of trust between us . . . because he wants to know and his mother didn't go to the workshops. . . . I told both of them what the workshops were about, the emergency contraception pills, how to take care of themselves . . . about sexually transmitted infections. (mother)

In addition, certain parents shared the information with other adults. The most commonly mentioned were sisters, sisters-in-law, and women neighbors, emphasizing the importance of sharing the new information:

> I: I was just going to ask if you had spoken with anybody else other than Jesus, with any other child?
> F: Yes, with two of my children and with my sister who had problems with her husband, and I've seen her dating someone else. I told her, "Well, you're an adult, but you need to understand, maybe we were taught differently, but today if you're going to have sex, you should use a condom." Yes, yes we gave out this information. . . . I said to her, "Well, if you are going to get into another mess, you should be well prepared for everything, look, even though I think you should know this at your age. You're an adult."
> I: Did she know it?
> F: She said yes, but I saw how she was listening intently when we were explaining everything to her.

On a few occasions, participants bought the prevention pack to give as a tool for other adults, so those adults could speak more easily with their children.

On several occasions, adolescents mentioned that after talking with their parents, they spoke with friends, siblings, and/or boyfriends or girlfriends about these topics. Certainly all of these cases represented positive movement; however, it is worth emphasizing the importance of speaking with a boyfriend or girlfriend, because this could lead to future conversations and negotiations about condom use.

Parent Acknowledgment That Adolescents Are Responsible for Their Own Sexual Behavior

Our most challenging objective with the workshops was to create awareness in the parents that allowed them to recognize their children's own decision-making capacities and rights of autonomy. This implied recognizing the adolescents' ability to make responsible decisions about their own body. This was a complicated and difficult process, because it required that parents understand that

when their children are adolescents, their job is primarily to redirect, advise, and present their children options for informed decisions, recognizing their right to make these decisions. Parents needed to understand that they could no longer control their adolescent child's behaviors. It was important that parents become aware of the need to not only provide complete information and maintain open dialogue with their child, but to also promote access to condoms and EC.

This last goal was not easy to either recognize or achieve. As previously stated, parents were not aware that their adolescent child might have already initiated sexual activities, or was about to. In addition, several parents considered that by giving their children access to methods such as condoms and EC, it would encourage their sexual initiation or indicate the parents' explicit approval to initiate sexual activity. Also, parents disapproved of health centers distributing condoms to their children, or their children carrying condoms. All this was particularly true during the first workshops. In spite of this challenge, at the end of the workshops and with the support of the prevention pack, some parents were clearly moving in the direction of acceptance:

> I: And what did you do with the bag [prevention pack], did he keep it?
> F: We told him that it was a gift that we would give him. We emphasized that it was not so that he would start having sex, but he should keep it because it had lots of information and that he should get used to carrying a condom with him. That in addition he shouldn't keep it for a long time in his wallet, or in his backpack, because the condoms can wear out. All those things that we were learning, we tried to tell him.

Finally, we should mention that even though many parents were not able to take this last step, we can demonstrate through the following brief statement that a few families were able to transmit to their children the benefits of condoms and EC (for its use in an emergency), and could recognize that the final decision would be made by their child and his or her partner:

> I told my son, "Look, these are the pills." My husband told him, "If the condom breaks, Son, these are the pills, but it is not good to abuse them. You must be careful and you should say to her [girlfriend], "Did you bring your pills just in case something happens? I didn't bring them. I brought my condom, you bring your pills, just in case something happens or something breaks." . . . Then if she wants something else, like she wants to get pregnant or something, well, then it's up to him. (mother)

Discussion

In Mexico, there are few educational interventions specifically oriented toward parents that offer sex education based on scientific evidence for the prevention of STIs and unplanned pregnancy, and few educational programs designed to develop the skills needed to transmit the information to their adolescent children. This intervention was a novel and pioneering approach in Mexico. Internationally, the majority of interventions have been evaluated through experimental or quasi-experimental designs (Blake et al., 2001; Dancy et al., 2006; Dilorio et al., 2006), which has been useful to measure the effect of such an intervention on knowledge, behavior, and abilities (Brody et al., 2004; Kirby et al., 2004; Klein et al., 2005; Lonczak et al., 2002; O'Donnell et al., 2005). However, with this study we illustrated the value of qualitative analysis to view the project's success from different, less obvious perspectives. Our qualitative achievement approach allowed us to identify ongoing changes that are not always evident with quantitative analyses. In this work, we identified changes, steps, and processes toward the gradual and effective communication that emerged in the interviews. In some cases changes were slight, involving only the manner of communication; in others the content became more informative, and in others the greatest change was noted in communication between the parents.

These small steps in communication between adolescents and parents are even more significant in countries such as Mexico, where for an important proportion of parents, access to clear information about these topics is limited, and where cultural conflict and/or fears hinder open dialogue about sex. Although some parents recognized (because of their perceptions, experience, and/or knowledge) the importance of talking with their children about sexual health, in many cases they felt insecure about their ability to do so, and because of this insecurity chose not to discuss sexual health. This is explained in part by the limited education among the parents, with few having attended high school themselves.

For more than two decades, compelling articles have reported more healthy sexual behaviors and greater self-care among adolescents when there is communication between the parent and child about sexuality and prevention methods (Dilorio, Pluhar, & Belcher, 2003; Jaccard, Dodge, & Dittus, 2002). In Mexico, the Catholic church's and other conservative groups' influence pertaining to sex education has created difficulties for parents and children to understand the advantages and importance of contraceptive knowledge. For many parents, silence or abstinence promotion is considered the only and best method of sex education for their children (Givaudan et al., 1994; Givaudan et al., 1997; Pick & Andrade,

1995). However, our results indicate that even those parents who could be described as conservative were in fact both receptive and interested in learning about STIs and pregnancy prevention, as well as in techniques to facilitate the transmission of this information, and did not think this was in conflict with their basic beliefs.

Education aimed at adolescents requires information directed toward sexual and reproductive health. Even though school and mass media are disseminating information about this topic, the information is not always complete or appropriate enough for adolescents to make decisions without risks. National statistics show that Mexican adolescents are vulnerable to STIs, pregnancy, and abortion, especially when they are not informed (Menkes & Suárez, 2003). Many parents of adolescents in high school have difficulty perceiving how close their children are to becoming part of the startling statistics. Our results indicate that once parents are sensitized to the risk their uninformed adolescent children run, initiating communication about sexual health is the natural and obvious next step. The reflection generated by the workshops produced a clearer perception of potential risk, and allowed parents for the first time to reconsider which is riskier, to give preventive information or not.

Some of the adolescents interviewed had already initiated sexual relations, and in all cases their parents were unaware of this. Before the workshops, none of these parents had provided information to their children. Afterwards, many of these parents transmitted pertinent information for their child's protection.

In Mexico, 60% of adolescents begin high school; however only 59% of those who start actually graduate (Secretaría de Educación Pública, 2008). Clearly this type of intervention will not reach adolescents who do not attend school, and who might be at even higher risk for STIs and unplanned pregnancy. Nonetheless, it is valuable to introduce projects such as this in schools because of the obvious advantages offered in terms of a defined structure to attain access to students and their parents. One strategy to help overcome this limitation might be to implement the curriculum at the secondary school, which the Ministry of Education in México reported that overall, 94% of young people attend (Secretaría de Educación Pública, 2008).

In many situations, it is common that before a new experience or process, the first step is usually the most difficult one. In this case, for parents to initiate the dialogue with their children, speak about it between themselves, or even to have a father accept that a mother should speak with her daughter, are all valuable first steps toward a positive change. They all represent changes in attitudes that can establish foundations so that future parent–child dialogues are more open and routine, and incorporate more concrete ideas for prevention. Change of attitude facilitates the interchange of ideas, and thus the dialogue on prevention can be established daily and in a less rigid way. This would have an even greater impact if implemented at an earlier age.

It has been demonstrated that power inequity in the couple is associated with women's lack of control over their bodies, their sexuality, and their reproductive health (Amuchástegui, 2001). These family structures contribute to the social constraints about sex education that constantly perpetuate social prejudices in relation to what men and women can know and do in relation to their sexuality (Szasz, 2003). The permeating stereotype of women who are passive, innocent, and ignorant when it comes to sexuality, as well as their inability to recognize or express their own sexual desires, are typical beliefs that reinforce social prejudices (Herrera & Campero, 2002). This lack of gender equity makes it socially inappropriate, for example, for women to know how to use and where to obtain condoms. However, as a result of the intervention, some fathers and mothers managed to move toward recognizing that their daughters are particularly vulnerable and, in some cases, managed to provide them information about and even access to condoms.

We agree with researchers who insist there is an enormous need to modify those attitudes, beliefs, and norms associated with sexual practices that cause women to be at a disadvantage, for instance, when negotiating condom use (Juárez & Gayet, 2005; Szasz, 2003). For example, the results of one study looking at Latin American mothers showed that even when mothers recognized that sexual norms were beginning to change, giving more freedom to women, they were not necessarily willing to encourage their daughters to embrace this freedom—for example, by pushing them to communicate their sexual needs to their partners (Giordano, Thumme, & Panting, 2009). If we hope to achieve important advances in gender equity in countries where gender issues are deeply embedded in social perceptions and practices, we need to design more innovative, creative, and systematic strategies to confront these issues within the family structure.

Although all components of the workshop were valuable, we believe that the prevention pack was a particularly important tool that gave the participants both a mechanism and added security to initiate parent–child dialogue. The participants' statements show that the pack contents were useful when speaking with their children. With its support, the parents managed to give precise information about STIs and correct condom use. When parents actually gave the prevention pack to their children, they took an important step in providing direct access to prevention methods and to recognizing their child's autonomy. This experience demonstrates the power of giving a simple, concrete, and appropriate tool to parents.

It is important to mention that the information about EC was not received as openly as that about condoms, and a smaller number of parents passed it on to their children. In Mexico, EC is a subject, as judged by the participants, that requires more education and promotion. This is due both to the lack of knowledge about the method and to the underlying prejudice against EC. The need for sexual and reproductive health services for adolescents in Mexico that respect their confidentiality and provide contraception at a low cost is only recently being acknowledged. We chose to sell the prevention pack to evaluate the importance parents would give to this type of aid (pamphlets + condoms + EC). We felt that even though it was low cost, parents would only buy the pack if they thought it was a useful purchase (granted, some might have bought the packs for their own personal use). If the pack had been given to the parents free of charge, it would have been impossible to know if it was considered a useful resource for speaking with their children. On the few occasions when a parent wanted to buy a prevention pack but was unable to pay, the pack was given free of charge.

This intervention was designed exclusively for parents, rather than being a multifaceted education strategy directed at both parents and adolescents, to evaluate the potential of parents as sex educators for their children in a country where the general perception is that parents are resistant to and wary of sex education. Although this study confirmed the benefits of interventions for parents of adolescents in this context, we believe direct involvement of adolescents is also important. Future work involving parents should also directly involve adolescents either together or in parallel with their parents. In addition to the school environment, new strategies and new actors must also be developed for out-of-school youth that will help create a domino effect for adolescent sexual health education. The fact that parents acknowledged speaking among themselves and/or with other children, young people, relatives, or neighbors shows a valuable indirect effect of the intervention. Even though our findings cannot be generalized, this study uncovered the nonobvious (or unplanned) benefits of the intervention, and showed that a short educational intervention designed with simple, focused objectives and concrete learning tools had the potential to achieve specific goals for improving sexual health communication.

The effect of family structure was not directly evaluated in this study, and although the majority of the participants were from families where parents were together, we cannot draw any conclusions regarding the effect of family structure on communication about STIs and unplanned pregnancy. Future studies should consider this variable to understand how family structure, in and of itself, impacts communication as well as knowledge about and access adolescents have to prevention messages.

Our experience confirmed that for parents in this context to even consider discussing sexual prevention with their children, an open acknowledgement of the importance of abstinence promotion and its value from a parent's perspective was essential. However, within this context of abstinence promotion, parents were encouraged and taught to include accurate and substantive information about condoms and EC. What was important for the parents to understand was that ultimately they do not control the behavior of their adolescent child, and that eventually their child will decide to express their sexuality. They came to believe that it was only beneficial for their adolescent child to know how to protect him-self or herself against STIs and unplanned pregnancy. Parents who promoted abstinence education needed to accept that underlying this, they were actually promoting delayed sexual initiation, and that prevention messages needed to be transmitted before initiation. Abstinence-only education strategies (those that promote no sex until marriage) have also been shown to be less effective (Kohler, Manhart, & Lafferty, 2008).

Working with parents is complex. Often, they are at a crossroads between the desire for their children to be informed, and their inexperience and inability to speak with them. Also, there is a dilemma about how to obtain a balance between informing, protecting, and granting independence to their children. In our study, both adolescents and their parents recognized their own personal conflicts, insecurity. and discomfort in talking about sexual health. The fact that parents identified these difficulties, while at the same time acknowledging the critical need for transmitting sexual health information to their children, indicated a clear step toward healthy communication, whether slight, intermediate, or collateral. If these aspects are not considered and measured as positive results, it will continue to be difficult to increase efforts and identify strategies to incorporate parents in countries with a social profile similar to Mexico. Similarly, this study helps to break the stereotype that parents do not understand the importance of speaking with their children, and are not effective communicators.

Finally, quantitative evaluation alone of this intervention might have led to the false impression that the parent-based intervention had little measurable impact, when in fact, important and varied achievements were occurring. Some parents took small initial steps to effective communication about sexual health, and others achieved more substantial and comprehensive transmission of key prevention information. Additional work including qualitative and quantitative analyses is warranted.

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References

Amuchástegui, A. (2001). *Virginidad e iniciación sexual en México: Experiencias y significados* [Virginity and sexual initiation in Mexico: Experiences and meanings]. Ciudad de México, México: Population Council/EDAMEX.

Blake, S., Simkin, L., Ledsky, R., Perkins, C., & Calabrese, J. (2001). Effects of a parent–child communications intervention on young adolescents' risk for early onset of sexual intercourse. *Family Planning Perspectives, 33*(2), 52-61.

Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., . . . Brown, A. C. (2004). The strong African American families program: Translating research into prevention programming. *Child Development, 75*(3), 900-917.

Dancy, B., Crittenden, K., & Talashek, M. (2006). Mothers' effectiveness as HIV risk reduction educators for adolescent daughters. *Journal of Health Care for the Poor and Underserved, 17,* 218-239.

Dilorio, C., Pluhar, E., & Belcher, L. (2003). Parent–child communication about sexuality: A review of the literature from 1980-2002. *Journal of HIV/AIDS Prevention and Education for Adolescents and Children, 5*(3-4), 7-31.

DiIorio, C., Resnicow, K., McCarty, F., De, A., Dudley, W., Wang, D., & Denzmore, P. (2006). Keepin' it R.E.A.L.! Results of a mother–adolescent HIV prevention program. *Nursing Research, 55*(1), 43-55.

Dittus, P., Miller, K., Kotchick, B., & Forehand, R. (2004). Why parents matter!: The conceptual basis for a community-based HIV prevention program for the parents of African American youth. *Journal of Child and Family Studies, 13*(1), 5-20.

Eastman, K., Corona, R., Ryan, G., Warsofsky, A., & Schuster, M. (2005). Worksite-based parenting programs to promote healthy adolescent sexual development: A qualitative study of feasibility and potential content. *Perspectives on Sexual and Reproductive Health, 37*(2), 62-69.

Giordano, F., Thumme, B., & Panting, G. (2009). The hopes and dreams of Honduran women regarding their daughters' sexuality. *Qualitative Health Research, 19*, 996-1009.

Givaudan, M., Pick, S., Alvarez, M., Collado, M. E., Weiss, E., & Gupta, G. R. (1994). *Intergenerational communication in the family: Implications for developing STD/HIV prevention strategies for adolescents in Mexico.* Retrieved from http://www.icrw.org/docs/archive/1994_rib_mexico.pdf

Givaudan, M., Pick, S., & Proctor, L. (1997). *Strengthening parent/child communication: An AIDS prevention strategy for adolescents in México City.* Retrieved from http://www.icrw.org/docs/archive/1997_rib_mexico.pdf

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research.* New York: Aldine.

Greene, J. C. (2000). Understanding social programs through evaluation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 981-999). Thousand Oaks, CA: Sage.

Gutierrez, J. P., Conde-González, C., Walker, D., & Bertozzi, S. (2007). Herpes simplex virus type 2 among Mexican high school adolescents: Prevalence and association with community characteristics. *Archives of Medical Research, 38,* 774-782.

Herrera, C., & Campero, L. (2002). La vulnerabilidad e invisibilidad de las mujeres ante el VIH/SIDA: constantes y cambios en el tema [The vulnerability and invisibility of women facing HIV/AIDS: Constant and changing issues]. *Salud Pública de México, 44*(6), 554-564.

Jaccard, J., Dittus, P., & Gordon, V. (2000). Parent–teen communication about premarital sex: Factors associated with the extent of communication. *Journal of Adolescent Research, 15*(2), 187-208.

Jaccard, J., Dodge, T., & Dittus, P. (2002). Parent–adolescent communication about sex and birth control: A conceptual framework. *New Directions for Child and Adolescent Development, 97*, 9-41.

Juárez, F., & Gayet, C. (2005). Salud sexual y reproductiva de los adolescentes: un nuevo marco de análisis para la evaluación y diseño de políticas [Sexual and reproductive adolescent health: A new framework for evaluation and policy design]. *Papeles de Población, 45*, 177-219.

Kirby, D. (2003). *Emerging answer: Research findings on programs to reduce teen pregnancy.* Washington DC: National Campaign to Prevent Teen Pregnancy, 2001.

Kirby, D. B., Baumler, E., Coyle, K. K., Basen-Engquist, K., Parcel, G. S., Harrist, R., & Banspach,S. (2004). The "Safer Choices" intervention: Its impact on the sexual behaviors of different subgroups of high school students. *Journal of Adolescent Health, 35*(6), 442-452.

Klein, J., Sabaratnam, P., Pazos, B., Matos-Auerbach, M., Graff Havens, C., & Brach, M. (2005). Evaluation of the parents as primary sexuality educators program. *Journal of Adolescent Health, 37*, S94-S99.

Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42(4), 344-351.

Lederman, R. P., Chan, W., & Roberts-Gray, C. (2004). Sexual risk attitudes and intentions of youth aged 12-14 years: Survey comparisons of parent–teen prevention and control groups. *Behavioral Medicine, 29*(1), 155-163.

Lefkowitz, E., Sigman, M., & Kit-fong, T. (2000). Helping mother discuss sexuality and AIDS with adolescents. *Child Development, 71*(5), 1383-1394.

Lonczak, H., Abbott, R., Hawkins, D., Kosterman, R., & Catalano, R. (2002). Effects of the Seattle social development

project on sexual behavior, pregnancy, birth and sexually transmitted disease outcomes by age 21 years. *Archives of Pediatrics and Adolescent Medicine, 156*, 438-447.

Menkes, C., & Suárez, L. (2003). *Sexualidad y embarazo adolescente en México* [Sexuality and adolescent pregnancy in Mexico]. Papeles de Población. Retrieved from http://redalyc.uaemex.mx/redalyc/src/inicio/ArtPdfRed.jsp?iCve=11203511

Módena, M.E., & Mendoza, Z. (2001). *Géneros y generaciones. Etnografía de las relaciones entre hombres y mujeres de la ciudad de México* [Gender and generations. Ethnography of relationships between men and women in Mexico City]. Ciudad de México, México: EDAMEX/Population Council.

Nuñez-Urquiza, R. M., Hernández-Prado, B., García-Barrios, C., González, D., & Walker, D. (2003). *Embarazo no deseado en adolescentes y utilización de métodos anticonceptivos posparto* [Unwanted adolescent pregnancy and postpartum utilization of contraceptive methods]. Salud Publica de Mexico, 45(Suppl.1), S92-S102.

O'Donnell, L., Stueve, A., Agronick, G., Wilson-Simmons, R., Duran, R., & Jeanbaptiste, V. (2005). Saving sex for later: An evaluation of a parent education intervention. *Perspectives on Sexual and Reproductive Health, 37*(4), 166-173.

Olaiz-Fernández, G., Rivera-Dommarco, J., Shamah-Levy, T., Rojas, R., Villalpando-Hernández, S., Hernández-Avila, M., & Sepúlveda, J. (2006). *Encuesta nacional de salud y nutrición* [Mexican national health and nutrition survey]. Cuernavaca, México: Instituto Nacional de Salud Pública.

Pan American Health Organization. (2007). *Modelo de consejería orientada a los Jóvenes en prevención del VIH y para promoción de la salud sexual y reproductiva. Una guía para proveedores de primera línea* [Youth-centered counseling for HIV/STI prevention and promotion of sexual and reproductive health. A guide for front-line providers]. Retrieved from http://www.paho.org/spanish/ad/fch/ca/sa-youth.pdf

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pick, S., & Andrade, P. (1995). Impact of the family on the sex lives of adolescents. Adolescence, 30(119), 667-675.

Pick, S., Givaudan, M., & Brown, J. (2000). Quietly working for schoolbased sexuality education in Mexico: Strategies for advocacy. *Reproductive Health Matters, 8*(16), 92-102.

Richards, L. (1997). QSR NUD*IST 4 software for qualitative data analysis. Melbourne, Australia.

Rouvier, M., Campero, L., Walker, D., & Caballero, M. (in press). *Factors that influence communication about sexuality between parents and adolescents in the cultural context of Mexican families.* Sex Education**.**

Secretaría de Educación Pública. (2008). *Sistema educativo de los Estados Unidos Mexicanos.* Principales cifras, ciclo escolar 2007-2008 [Mexican educational eystem. Key numbers, scholar cycle 2007-2008]. Retrieved from http://www.dgpp.sep.gob.mx/Estadi/Principales_cifras_2007_2008.pdf

Strauss, A., & Corbin, J. (2003). *Bases de la investigación cualitativa técnicas y procedimientos para desarrollar la teoría fundamentada* [Basics of qualitative research: Grounded theory procedures and techniques]. Medellín, Colombia: Ediciones y Universidad de Antioquia.

Swann, C., Bowe, K., McCormick, G., & Kosmin, M. (2003). *Teenage pregnancy and parenthood: A review of reviews*. Health Development Agency. Retrieved from http://www.gserve.nice.org.uk/niceMedia/documents/teenpreg_evidence_briefing.pdf

Szasz, I. (2003). Pensando en la salud reproductiva de hombres y mujeres [Thinking of reproductive health for men and women]. In M. Bronfman & C. Denman (Eds.), *Salud reproductiva: Temas y debates* [Reproductive health: Themes and debates]. Ciudad de México, México: Instituto Nacional de Salud Pública.

Thelus, R., Bondy, M., Wilkinson, A., & Forman, M. (2009). Pubertal development in Mexican American girls: The family´s perspective. *Qualitative Health Research, 19,* 1210-1222.

Villaseñor, M. (2008). Qué sabemos de la perspectiva que los adolescentes tienen sobre la sexualidad y la educación sexual? [What do we know about adolescents' perspectives regarding sexuality and sexual education?]. In Stern Claudio (Coord.), *Adolescentes en México: Investigación, Experiencias y Estrategias para Mejorar su Salud Sexual y Reproductiva* [Adolescents in Mexico: Research, experiences and strategies to improve sexual and reproductive health] (pp. 73-114). Ciudad de México, México: El Colegio de México/Population Council.

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