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ORIGINAL ARTICLE

Barriers and facilitators to accessing sexual and reproductive health care for adolescents in protection and justice programs in Chile

Barreras y facilitadores para el acceso a la atención en salud sexual y reproductiva de adolescentes en programas de protección y justicia en Chile

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What do we know about the subject matter of this study?

In Chile, adolescent sexual and reproductive health (SRH) faces significant challenges. Despite progress, gaps in access to services persist, especially for groups whose rights have been violated, such as adolescent girls in protection and justice programs.

What does this study contribute to what is already known?

This study provides background information and recommendations for state health, protection, and justice teams to reduce barriers to accessing SRH services for adolescent girls in protection and justice programs.

Abstract

Sexual and reproductive health (SRH) of adolescents in Chile faces significant challenges. Despite progress, gaps in access to services persist, especially for groups whose rights have been violated, such as adolescents who attend protection and justice programs. **Objective:** To analyze the barriers and facilitators of access to sexual and reproductive health services in Primary Health Care for adolescent women who attend protection and justice programs in the Metropolitan Region of Chile. **Subjects and Method:** Qualitative and exploratory research with intentional sampling of adolescent women in protection and justice programs, and primary care professionals and those of the programs. Semi-structured qualitative interviews were conducted. The analysis was carried out using a constructivist thematic approach, establishing a categorization and coding system. **Results:** 16 adolescents and 24 professionals were interviewed. The adolescents identified the following barriers to

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accessing services: opening hours, the obligation to attend with an adult when they are minors, lack of knowledge about administrative procedures and long waiting times. The professionals pointed out difficulties such as insufficient implementation of adolescent health policies and programs, high staff turnover, work overload and problems in intersectoral coordination. They also highlighted the mutual mistrust, prejudices and lack of knowledge between the health, protection and justice systems, the stigmatization of adolescent users, and the perception of this population as "complicated" to care for. They also emphasized the lack of awareness of those working in health regarding problems of rights violations. Among the facilitators, the recognition of the status as a priority population, the relationship of trust with the teams, educational interventions on sexuality, legal regulations that guarantee confidentiality, and the role of the professional in charge of intersectoral coordination, were key elements to improve access to health services. **Conclusions:** There are institutional barriers that hinder access by adolescents from protection and justice programs to sexual and reproductive health services in primary care. Knowledge and effective implementation of public policies that prioritize this population represent a key facilitator.

Introduction

Access to sexual and reproductive health (SRH) services is essential throughout the life cycle of individuals, including adolescence. There has been progress in this area, such as the expansion of adolescent-friendly spaces in primary health care (PHC) which, by 2022, have reached 375 nationwide, the increase in contraceptive use among young people aged 15-29 years, reaching 84.5% in 2022, and the decrease in the adolescent fertility rate from 60 births per 1000 inhabitants two decades ago to 11.9 births per 1000 in 2021[1,2,3]. However, there are still inequalities that affect the SRH of adolescent girls, especially those under 15 years of age, sex-gender diversities, migrants, and those with multidimensional poverty indicators, who face the most unfavorable consequences of the lack of access to SRH services, such as sexual violence, unintended pregnancies, and sexually transmitted infections[4,5,6]. Among these groups, adolescents within the protection and justice systems have been described as having a high incidence of physical, mental, and sexual health problems[7,8,9,10,11]. These adolescents are considered a priority group within national public policies on health and social security, and their entry into the protection and justice system is an opportunity to link them to the health system on time[1,12].

In Chile, the State protection system for children and adolescents guarantees the welfare of this group, which presents violence, abuse, or neglect in their life trajectory. This system considers comprehensive care in specialized outpatient or residential centers, psychological and social support, legal protection, and education, whose specific intervention is determined according to the reason for admission and initial diagnosis. In addition, it promotes the social inclusion of children and adolescents in vulnerable situations, facilitating their development and a better future. This system is known as the National Service for the Specialized Protection of Children and Adolescents. In addition, the judicial system has specialized units for children and adolescents that guarantee their rights during the sanctioning processes, establishing either custodial or non-custodial measures (starting at age 14). These processes follow different regulations than those for adults and are governed by the Adolescent Criminal Responsibility Law (20,084) and the National Youth Social Reintegration Service. This service works in coordination with other state agencies and civil society to help adolescents abandon criminal behavior, promote social integration and reintegration, and ensure the exercise of their rights.

Despite the interest and concern expressed by the health authorities to establish inter-institutional and cross-sectoral mechanisms and coordination to provide timely and effective health care to children and adolescents under state protection and justice, effective access to these services is often not achieved due to barriers that have not been studied in our context[12,13,14].

The literature mentions as barriers to accessing SRH services the ambivalent attitude of adolescent girls towards care, due to negative experiences and stigmatization by health providers[9,10,11,13,15,16,17,18]. Difficulties in collaboration between health, protection, and justice institutions are also noted[5,8,19,20,21]. A UNICEF study carried out in protection institutions in Chile points out that the articulation with external networks is weak, which affects the rights restitution of children and adolescents, recommending a coordinated response with health and education[22].

The objective of this study was to analyze the barriers and facilitators of access to SRH services in PHC for adolescent girls in protection and justice programs in the Metropolitan Region, Chile, from the perspectives of adolescent girls, health professionals, and programs.

Subjects and Method

Qualitative and exploratory study, focused on the experiences of those who participated, seeking to facilitate the description of new elements that contribute to the understanding of the phenomenon[23,24].

A purposive sampling was used to include adolescents, PHC professionals, and professionals from protection and justice programs. The inclusion criteria for adolescents were to be female (cis or trans), to be between 10 and 19 years old, and to be part of a protection and/or justice program. For professionals, the inclusion criterion was to have at least one year of experience in the position.

Contact with the adolescents and professionals was made through key informants from both programs and PHC centers. Through them, the invitation to participate was extended to those who expressed interest in being included in the study, beginning the procedure established for the signing of the informed consent.

As a data production technique, the semi-structured qualitative interview was considered, as it is flexible and dynamic. The thematic script used in the interviews was derived from the research objectives and the review of evidence. Two scripts were developed, one for adolescents and the other for professionals, which were validated by experts in the areas of protection, justice, and health.

The interviews were conducted between April 2022 and April 2023, at a time and place mutually agreed upon by participants and the research team. They lasted between 45 and 60 minutes and were recorded and transcribed. The transcription was given a code in order to anonymize them. To determine the maximum number of interviews to be carried out, the information saturation criterion was used, that is, the moment at which new information or data is no longer obtained[24].

The data collected were organized to facilitate qualitative content analysis. A constructivist thematic analysis approach was used, leading to the establishment of a categorization and coding system. These were supplemented with emerging axial codes. The coding process was carried out by the research team, who met to discuss the identified codes, ensuring their consistency. They then performed intercoder validation to ensure the reliability of the analysis and MAXQDA software was used to facilitate the process. Procedures were implemented to ensure the credibility, transferability, reliability, and verifiability of the qualitative research. Finally, an expert workshop was conducted to validate the results.

Results

Sixteen adolescents between 11 and 18 years of age participated, with a mean age of 15.4 years, all were in school, and three were of foreign nationality. Two identified themselves as transgender. Four were living in protective family residences, nine were attending outpatient protective programs, and two were attending juvenile justice programs in the same modality.

Within the group of professionals, 13 were working in health care, 11 in protection and justice programs, and 20 were women. The mean age was 35 years with a mean of 10 years of experience in the position. The professions referred to were midwife, psychologist, social worker, and occupational therapist.

Institutional barriers identified by adolescent girls

Adolescent girls identified that the opening hours of PHC centers are not compatible with their school schedules, which represents an obstacle to accessing contraceptive services. Another barrier mentioned is the requirement to attend with a responsible adult when under age. It is important to note that many of them do not have a responsible adult available, as their caregivers are not present, have violated their rights, and/or do not have the required competencies to perform their role, which makes this requirement a significant obstacle for this group. In addition, they express that attending along with an adult makes them uncomfortable, especially when health care providers address sensitive and private issues related to sexuality in their presence. Another barrier identified is the lack of knowledge about the procedures and their rights to access contraceptive services, which generates insecurity when seeking health care. They also report long waiting times for an appointment, which discourages them from attending their checkups. Finally, they mention the fear of being judged by health center staff as another barrier (Table 1).

Institutional barriers identified by professionals

Health teams highlighted as barriers to access for adolescent girls to SRH services the incomplete, unstable, and insufficient implementation of sexual health policies and programs for the adolescent population in general, and especially for the group in protection and justice programs, in addition to the lack of resource allocation.

Besides, both health teams and those of protection and justice programs, identified as barriers the high turnover of professionals, coupled with work overload, especially in the case of those responsible for linking the intersectoral work between health and protection and justice programs, fulfilling in some cases, multiple roles without adequate training, which leads to difficulties in collaboration, coordination, and communication between the areas involved. Another obstacle pointed out was the distrust, lack of knowledge, and prejudice from the health sector towards the work

Table 1. Barriers to SRH care from the perspective of adolescents attending protection and justice programs

Category	Subcategories	Quotes
Institutional Barriers	Service hours	The hours are really complicated for me because when I get out of school, they're already… they're not… they're not open anymore… So, needing an adult for this kind of… I don't know, contraception, is also a bit complicated for me. (EA14)
	Waiting time	I go to the CESFAM, enter my RUT, and wait—almost always about 3 hours to get the injection from the pharmacy, and then another hour waiting to get it administered… Every month… If the wait time is too long, I have to go on a day when I have nothing else to do, otherwise, I won't have time for my other tasks. (EA15)
	Need for adult assistance	Yes, they told me I couldn't go alone because, well, I've always had social workers and all that behind me. I talked to my tutor and told her I wanted to go. She said, "Look, I talked to them… they told me to go tomorrow at 6 a.m. to book an appointment, and you have to go with an adult, because if you're a minor, they won't let you in." (EA16)
	Fear of being judged	There are always adults to turn to, but sometimes we don't because of the fear of what they might say. (…) Right, that they'll react badly, like "Oh, so young and already doing this" or "Oh, when I was your age…" or "How can you do that? How can you even like that?" (…) Yes, they're too quick to judge, I'd say. They scold you for everything, and you can't tell them anything because it's always "No, that's not how you do it, that's wrong" or "You shouldn't be doing that, when I was your age, I wasn't like that." But… We're teenagers, we need to experience things ourselves to understand them. (EA12)
	Insufficient sexual education	Not many moms or dads give enough trust to talk about it. Some say things like, "No, if you get involved with this person or do this, I'll hit you, and if you get pregnant, I'll kick you out of the house." But no, we should talk about it. There are many ways to take care of ourselves, lots of options available—contraceptives, pills, condoms, injections, and many other things. So instead of shutting down the conversation with something like, "No, if you get pregnant, I'll kick you out," it should be, "No, daughter, let's talk. What's going on? We'll find a solution." Don't immediately go for aggression or something like that. (EA12)

carried out by the protection and justice programs, especially in the case of outpatient programs. It was also noted that the teams of protection and justice programs lacked knowledge about the functioning and organization of the health system.

The teams of the protection programs identified multiple barriers in the health system for adolescent access, among them, the delivery of appointments at times that adolescents cannot attend due to their school obligations. Likewise, it was found that health teams have a stereotypical view of adolescents who attend protection programs, which predisposes them to assume that they have drug use, criminal history, and problematic sexual behavior, perceiving them *a priori* as a "complicated" population for care. Regarding protection and justice programs, health professionals in general are not sufficiently sensitized to issues of rights violations in the sphere of sexuality, such as sexual exploitation and the damage that this implies in the life trajectory of these adolescents (Table 2).

Facilitators identified by adolescent girls

From the perspective of adolescents in residential protection programs, access to health services is perceived without major obstacles, knowing that they are a priority population. However, it was observed that this is not perceived in the same way for adolescents in outpatient protection programs or juvenile justice programs.

In general, adolescents perceive that having a relationship of trust with the professionals of the programs they attend facilitates access to health services so that during the diagnosis and intervention process they can express their interest or health needs in SRH issues.

Another positive aspect, despite its low occurrence, refers to sexual education, either in their schools, through informative talks or workshops conducted by PHC health personnel, or in the protection or justice programs themselves. Adolescent girls consider it beneficial to have these instances to improve their knowledge of sexuality and thus facilitate access to health services.

The adolescents emphasize the importance of training on sexuality issues in adulthood so that professional teams and their families can provide better guidance and support to young people in this area from a vision focused on well-being, free of stereotypes (Table 3).

Facilitators identified by professionals

A series of facilitators for access to SRH care for adolescents were identified, which coincided among health professionals and professionals from protec-

Table 2. Barriers to SRH care from the perspective of health and protection and justice program professionals

Category	Subcategory	Quote
Institutional Barriers	Lack of effective implementation of adolescent health programs	I mean, I think the program is very recent, and I also believe there wasn't a proper awareness campaign when it was launched. So, that means people don't necessarily understand that these prioritized services exist. (EPS5)
	Denial of care by health professionals	Exactly. Doctors, in particular, say, "No, I don't want to see adolescents, don't assign me adolescents." But today, in the role of a primary care physician, in this family health model that we're working with, and in this new multimorbidity model we're incorporating at the public health level, they should be seeing all types of patients, you know? So yes, today there is an exclusion, I feel, by some professionals who don't like treating this type of patient. (EPS2)
	Mutual lack of knowledge and trust between institutions	In primary care, there is a complete lack of knowledge about the wide range of intervention professionals working in "Mejor Niñez." There are many, and often it leads to confusion because, for example, we have programs related to school reintegration, which we also have in municipal adolescent programs within primary care. At some point, we ask ourselves, "Are we over-intervening in this case? How do we manage and divide the workload?" So, there's a lot of difficulty in understanding what each service does, especially because there are so many. While we've tried to hold meetings to understand the system, soon after, another system emerges. (EPS2)
	Lack of awareness of intersectoral professional roles	…When I started meeting with other psychologists and teams working in this psychosocial support program, I realized that the CESFAMs [Family Health Centers] in the district have that work divided among different people. One is the psychologist for psychosocial support, another is the psychologist for the SENAME [Protection Program] cases. (EPS3)
	High staff turnover and work overload	There are CESFAMs, for example, that currently don't have a social worker. They are just now reorganizing and restructuring, so they leave interventions and waiting lists behind. Professional turnover is also a big issue. I think it's related to working conditions—the salaries are low. So midwives leave, gynecologists return, or there's no gynecologist at all. (EMN2)
	Lack of knowledge about regulations for adolescent care	Right now, we have five girls who we cannot register in the health system because they don't have responsible adults. We've had to take it upon ourselves to seek out independent feminist gynecologists who can come here and give workshops. (EMN2)
	Difficulties in inter-institutional information transfer	This also mainly depends on the professional you're dealing with, because many cite patient privacy laws, saying they cannot share information and blah blah blah… without understanding that they're not just giving the information to anyone. We also handle information properly, and this data is needed for intervention purposes, not for anything else. (EMN3)
	Long waiting times to access care	To be completely honest with you, I have worked in the Third Region, in San Bernardo, and in La Granja, and the principle of timely access just doesn't apply. Let me give you an example—when I worked in La Granja and we tried to coordinate with the "Mejor Niñez" mental health representative at Sótero del Río Hospital, the responses took forever, forever. We waited four, five, six months. (EMN6)

tion and justice programs. Among them, the existence of legal regulations that protect the confidentiality of care, the possibility of accessing contraceptive care without the requirement of being accompanied by an adult, and the provision of contraception to adolescents regardless of their age were highlighted. It was also found that the prioritization of care for adolescents enrolled in these protection and justice programs, together with the articulation of intersectoral work between health and protection and justice teams, are key elements to improve access to health care and that their role should be strengthened and made more visible.

Other initiatives and programs aimed at the general adolescent population were also identified as facilitators for access to health care for this specific group of adolescents, such as friendly spaces. In addition, the importance of intersectoral coordination bodies was highlighted, such as local children's networks, where different community institutions from civil society, government, and related to the protection of the rights of children and adolescents, and the local program of-

Table 3. Facilitators for SRH care from the perspective of adolescents attending protection and justice programs

Category	Subcategories	Quotes
Institutional Facilitators	Priority population	They didn't ask me, but my tutor called the clinic, and they said, "Have her come at 6 a.m. because that's when we give out appointments, and we'll give her priority for the day." And they saw me that same day. [E]: And did they give you priority because you were in the program? Yes, because I was in the PIE program. [E]: Perfect. So, just for being in the PIE program, they said, "No, she has priority; we'll see her today." Yes, they spoke with the PIE tutor and said, "Oh, she's from PIE? Tell her to come at 6 a.m., and we'll prioritize giving her an appointment that same day." (EA16)
	Trusting relationships with significant adults	Maybe at a clinic, with a midwife, like you said, or at school, with the school coexistence team—many times, the psychologists are really nice and always available. Sometimes even the teachers are, so there are always adults we can turn to. (EA12)
	Sex education	There's still a lot of closed-mindedness, especially in families. But in my experience, that wasn't the case. My mom taught me about all of this from a very young age. It was never like, "Oh, the stork brings babies." No, my mom always explained everything to me. She taught me how to put on condoms when I was very young. She would tell me that before having sex, I had to tell her—before, not after. She was always super open; it was something very normal. But I think nowadays, for teenage girls, this is something they mostly talk about with their friends. (EA16)

Table 4. Facilitators for SRH care from the perspective of health and protection and justice program professionals

Category	Subcategories	Quotes
Institutional Facilitators	Government regulations prioritizing populations from protection programs	Yes, I feel that there have been supports from the central level that didn't exist before. Supports regarding confidentiality, ensuring that care is not denied, and providing contraceptive methods regardless of age or condition. The fact that these regulations arrived—support from the central level, in writing—has significantly improved care. But I feel like this happened very recently. I mean, they came in, what, maybe five years ago at most? I don't remember exactly. Before that, it was very much about having to ask nicely, hoping that whoever wanted to help would do so, while those who didn't want to could refuse. (EPS1)
	Specific health programs for adolescents	Now, for us, comprehensive health check-ups are key, you know? Because that's where a lot of things come to light. Midwives, generally, within the adolescent program, process everything through those check-ups. It's like their entry point, a way to get a broad overview of the situation, and from there, we prioritize and decide what to provide first. This tool—the comprehensive health check-up—has helped us organize these issues a bit, and that's where we assess the situation. Things need to be handled in an organized way. (EPS2)
	Professionals aware of adolescent health needs	We are constantly training and raising awareness within our networks. These trainings are broad calls where we invite different stakeholders. Sometimes the health sector participates, but not always. (…) Our main goal is to ensure that the network understands the indicators. Why? Because it's the instance where they can say, "You know what? There's an indicator of sexual exploitation, and we need to refer this case immediately to our program." Because, in the end, what happens to these kids is that they get referred to one program, then that program says, "You know what? This doesn't fit our profile," and they just keep passing them around. (EMN7)

fered aimed at the adolescent population participate, as well as the establishment of information flows and intersectoral collaboration through local protocols and coordination meetings (Table 4).

Flexibility in adolescent care by PHC professionals and training on the rights and gender perspective for adolescent SRH care are key elements to improve access to health care for this population, as well as its quality.

Discussion

The study identified multiple difficulties and institutional facilitators for the effective and timely access of adolescents attending protection and justice programs to SRH services in PHC. Some difficulties were health care schedules, and lack of empathy on the part of health personnel regarding sensitive issues, such as the causes of admission to the programs and the stig-

ma associated with this. Several of these obstacles have been described in the literature for the adolescent population in general and for those in protection and justice programs[9,10,11,16,17,18]. The latter is also described as a population with specific health needs and challenges, with more frequent sexual risk behaviors and worse sexual health outcomes. This is likely due to early adverse experiences such as abuse, neglect, and disrupted relationships with caregivers, among others[9,10,11,15,16]. In this sense, it is recommended that health teams consider life trajectories, traumatic experiences, and social and family contexts, among other factors, to provide comprehensive and effective care.

In our study, it was found that both SRH care needs and the ways of delivering this care are comparable to the recommendations for adolescents in general, i.e., based on respect for human rights and quality of care, considering confidentiality, progressive autonomy, and avoiding re-victimization. The differences, therefore, do not lie in the clinical care provided in the consultation room but rather in administrative aspects, such as appointment management and follow-up of subsequent check-ups, to promote adherence to the health center and the ability of adolescents to exercise their sexual and reproductive rights.

In order to strengthen the aforementioned administrative aspects, intersectoral coordination is fundamental, which has been identified in this study and others as a critical point among the obstacles to guaranteeing access[5,20,22,25]. The perception of the professionals is that there is an inadequate exchange of information between the programs and the health network. These difficulties are related to patient information protection laws, but also to power relations between institutions and mutual distrust. This last point is observed in the undervaluation of psychosocial intervention from the biomedical perspective, added to the lack of clarity in the roles of the different participants and the scarce opportunities for collaborative and interdisciplinary work within the coordination between health and protection and justice programs. All of the above contrasts with the recommendations for effective intersectoral collaboration, such as the motivation of the actors involved, knowledge of the objectives and mutual benefits, good personal relationships, and trust between institutions[21].

Another persistent barrier, identified by both adolescents and professionals, was the requirement for a minor to be accompanied by an adult for healthcare services, a barrier that has been described in other studies[13,14]. It is important to note that in Chile the regulations state that "*Everyone has the right to receive education, information, and guidance on fertility regulation, in a clear, understandable, complete and, when appropriate, confidential manner*", this includes adolescents, and only refers to the adult, "*in those cases in which the emergency contraceptive method is requested by a person under 14 years of age, ..., shall proceed to the delivery of such medication, informing, subsequently, the father or mother of the minor or the responsible adult that the minor indicates*"[26]. Therefore, the requirement of attending with an adult to access health services, such as the initiation of a contraceptive method, is often done as a professional and institutional safeguard, not to protect the best interests of the adolescent, demonstrating a lack of knowledge in the application of regulations by health providers, in addition to an adult-centered and family-centered vision, which perpetuates the idea that adolescents are incapable of making decisions about their SRH[14.] This requirement is especially complex in the case of this population, who, given their history of violations, do not necessarily have trusted adult figures to attend health care, either because they do not exist, the low priority given by adults to this accompaniment by due to prejudice and/or lack of information, lack of availability due to work schedules, especially in single-parent households, among other circumstances that prevent them from complying with this arbitrary requirement.

Knowledge of the regulations and policies related to adolescent health care in general and the prioritization of this population, in particular, is a facilitator, both for the exercise of adolescent SRH rights and for the health interventions carried out by professionals; on the contrary, not knowing them becomes a barrier.

As for the preconceptions and stigmas of the health teams towards adolescents attending protection programs or sanction for unlawful behavior, although they have been described in other studies[15,16,17], in this one, they were mostly referred to by professionals from justice programs and not by the adolescents themselves. This may be because most of the adolescents came from the protective environment, identifying a more paternalistic and compassionate view of their situation, especially for those living in residences, who recognized the fact that health professionals knew about their situation of institutionalization as a facilitator for accessing their health center. This contrasts with the punitive views that adolescent girls receive from justice programs, who have committed crimes and may be seen as people of low moral standards[15,16].

This study offers an analysis aimed at identifying and understanding the gaps that persist in adolescents' access to SRH services despite current public policies aimed at eliminating them. It is essential to promote the dissemination and effective enforcement of regulations that safeguard priority care and coordinated intersectoral management, as well as to implement training, coordination, communication, and collaboration mechanisms that optimize inter-institutional

work and thus ensure respect for the rights and needs of adolescents in the health care context.

Conclusions

Multiple institutional difficulties hinder the effective and timely access of adolescent girls in protection and justice programs to SRH services in PHC. Adequate knowledge and application of existing public policies that favor and prioritize access for this population is a relevant facilitator. It is recommended that health teams consider the life trajectory and traumatic experiences of these adolescents, especially around sexuality, when providing health care, from a comprehensive perspective focused on wellbeing. Research is needed to strengthen intersectoral work between health and other state sectors.

Ethical Responsibilities

Human Beings and animals protection: Disclosure the authors state that the procedures were followed according to the Declaration of Helsinki and the World Medical Association regarding human experimentation developed for the medical community.

Data confidentiality: The authors state that they have followed the protocols of their Center and Local regulations on the publication of patient data.

Rights to privacy and informed consent: The authors have obtained the informed consent of the patients and/or subjects referred to in the article. This document is in the possession of the correspondence author.

Conflicts of Interest

Authors declare no conflict of interest regarding the present study.

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References

1. Ministerio de Salud, Programa Nacional de Salud Integral de Adolescentes y Jóvenes; 2023.
2. Instituto Nacional de la Juventud. Ministerio de Desarrollo Social y Familia [Internet]. X Encuesta Nacional de la Juventud; 2022 [consultado el 4 de noviembre de 2024]. Disponible en: https://www.injuv.gob.cl/sites/default/files/10ma_encuesta_nacional_de_juventudes_2022.pdf
3. Instituto Nacional de Estadísticas (INE), Subdepartamento de Demografía Departamento de Estadísticas Demográficas y Sociales, Síntesis de Resultados Estadísticas Vitales Período de información. 2021.
4. Rodríguez Vignoli J, Roberts, A. El descenso de la fecundidad adolescente en Chile: antecedentes, magnitud, determinantes y desigualdades. Serie de Estudios N° 12. Santiago: Instituto Nacional de la Juventud. 2020.
5. Bai Y, Wells R, Hillemeier MM. Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. Child Abuse Negl. 2009;33(6):372-81.
6. Robards F, Kang M, Usherwood T, et al. How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. J Adolesc Health. 2018;62(4):365-81
7. American College of Obstetricians and Gynecologists. Reproductive health care for incarcerated women and adolescent females. Committee Opinion No. 535. Obstet Gynecol. 2012;120:425-9.
8. Kern MR, Duinhof EL, Walsh SD, et al. Intersectionality and Adolescent Mental Well-being: A Cross-Nationally Comparative Analysis of the Interplay Between Immigration Background, Socioeconomic Status and Gender. J Adolesc Health. 2020;66(6S):S12-S20.
9. Robards F, Kang M, Steinbeck K, et al. Health care equity and access for marginalised young people: A longitudinal qualitative study exploring health system navigation in Australia. Int J Equity Health. 2019;18(1):1-14.
10. Braverman PK, Murray PJ, Adelman WP, et al. Health care for youth in the juvenile justice system. Pediatrics. 2011;128(6):1219-35.
11. Farid NDN, Rus SC, Dahlui M, et al. Predictors of sexual risk behaviour among adolescents from welfare institutions in Malaysia: A cross sectional study. BMC Public Health. 2014;14(Suppl 3):S9.
12. Ministerio de Salud, Ministerio de Justicia, Ministerio del Interior, Ministerio de Desarrollo Social. Lineamientos técnicos para la implementación del sistema intersectorial de salud integral, con énfasis en salud mental, para niños, niñas, adolescentes y jóvenes con vulneración de derechos y/o sujetos a la ley de responsabilidad penal adolescente [Internet]. 2023. Disponible en: https://diprece.minsal.cl/wp-content/uploads/2024/03/Lineamientos-Tecnicos-SISI-2023.pdf
13. Sadler M, Obach A, Luengo X, et al. Estudio barreras de acceso a los servicios de salud para la prevención del embarazo adolescente en Chile. Santiago: Ministerio de Salud de Chile; 2011.
14. Leal I, Luttges C, Troncoso P, et al. Conocimientos y práctica clínica de los proveedores de salud para la prevención del embarazo adolescente según marco legal Chileno. Rev Med Chil. 2016;144(5):577-84.
15. Ti A, Burns R, Barnert ES, et al. Perspectives on Patient-Centered Family Planning Care from Incarcerated Girls: A Qualitative Study. J Pediatr Adolesc Gynecol. 2019.
16. Perminio HB, Silva JRM, Serra ALL, et al. National policy for comprehensive health care for adolescents deprived of liberty: An analysis of its implementation. Cience Saude Coletiva. 2018;23(9):2859-68.

17. Nascimento MA, Uziel AP, Hernández Jimena de Garay. Young men in juvenile detention centers in Rio de Janeiro, Brazil: gender, sexuality, masculinity and health implications. Cad. Saúde Pública. 2018;34(2).
18. Robertson RD. The invisibility of adolescent sexual development in foster care: Seriously addressing sexually transmitted infections and access to services. Children and Youth Services Review 2013;35(3):493-504. https://doi.org/10.1016/j.childyouth.2012.12.009
19. Ball B, Hoefer S, Faulkner M, et al. Innovation in Sexuality and Relationship Education in Child Welfare: Shifting Toward a Focus on Ongoing Conversations, Connection, and Consent. Prev Sci. 2023;24(Suppl 2):163-73. doi: 10.1007/s11121-022-01476-z.
20. Ndumbe-Eyoh S, Moffatt H. Intersectoral action for health equity: a rapid systematic review. BMC Public Health. 2013;13:1056. doi: 10.1186/1471-2458-13-1056. PMID: 24209299; PMCID: PMC3830502.
21. Cunill-Grau N. La intersectorialidad en las nuevas políticas sociales: Un acercamiento analítico-conceptual. Gest. polít. pública [online]. 2014;23(1):5-46.
22. UNICEF. Estudio para el fortalecimiento de los Programas Ambulatorios del Servicio Nacional de Menores. 2019.
23. Hernández Sampieri R, Fernández Collado C, Baptista Lucio P. Metodologías de la Investigación, México, Editorial Mc GrawHill, 6ta edición, 2014.
24. Flores R. Observando observadores. Una introducción a las técnicas cualitativas de investigación social, Santiago de Chile, Ediciones UC, 2009.
25. Kelly MA, Barnert E, Bath E. Think, Ask, Act: The Intersectionality of Mental and Reproductive Health for Judicially Involved Girls. Journal of the American Academy of Child and Adolescent Psychiatry. 2018;57(10):715-18. https://doi.org/10.1016/j.jaac.2018.07.870
26. Ley 20.418. Fija Normas sobre Información, Orientación y Prestaciones en Materia de Regulación de la Fertilidad. Biblioteca del Congreso Nacional, (28-02-2010). [Consultado el 5 de noviembre de 2024]. Disponible en: https://www.bcn.cl/leychile/navegar?idNorma=1010482