

Adolescent Sexual Health and the Dynamics of Oppression: A Call for Cultural Competency

Issues at a Glance

Youth who face prejudice and discrimination by virtue of their identity, life experience, or family circumstances disproportionately experience teen pregnancy and sexually transmitted infections (STIs), including HIV. Such young people may include youth of color, those from low-income families, immigrants, and gay, lesbian, bisexual, and transgender (GLBT) youth. Research often focuses on the socio-economic factors—such as poverty, family distress, and access to health care—which contribute to teenage sexual risks.¹ Little research, however, focuses on the effect on young people of discrimination based on their age, race/ethnicity, gender, class, and/or sexual orientation.²

This paper encourages those who work with youth to understand the impact of prejudice and discrimination on vulnerable adolescents, to assess and address their needs, and to build on their assets. In prevention programming, it is essential to empower young participants by involving them in all aspects of designing and running programs for youth. It is equally essential to provide culturally appropriate interventions, with culturally competent adult and youth staff.

Step One: Understand the Impact of Prejudice and Discrimination on Young People³

Learn as much as possible about the connections between oppression and the sexual and reproductive health of young people. Prejudice and discrimination have a powerful impact on vulnerable youth. Policy makers and program planners need to recognize that:

- 1) The historical and cultural context of reproductive and sexual rights, especially for women of color and low-income women, is one of persistent inequality.** In designing prevention programs, service providers must recognize the impact of inequality on youth, especially on young women of color and youth from impoverished communities. Persistent inequality in U.S. health care has resulted in communities having painful memories of medical abuses, as well as anger, distrust, and suspicion of public health and medical providers and government agencies.⁴ Prevention programs that work with young women of color must not overlook the United States' history of reproductive rights violations. For example, by 1982, approximately 24 percent of African American women, 35 percent of Puerto Rican women, and 42 percent of Native American women had been sterilized, compared to 15 percent of white women.⁴ The eugenics movement, the Tuskegee syphilis study, and recent efforts to restrict states from offering health services to immigrants all reflect racist and discriminatory reproductive health policies in the United States, as do efforts focused on distributing Norplant and Depo-Provera to low-income adolescents and welfare recipients.⁴
- 2) Prejudice and discrimination have strongly negative impacts on the health of young people.** Prejudice and discrimination, at individual and institutional levels, contribute to high morbidity and mortality rates among youth. Research demonstrates that institutionalized homophobia results in high rates of violence toward GLBT youth in schools and communities. The violence and verbal abuse result in feelings of isolation as well as high rates of suicide and suicide attempts, substance use, and risk for HIV/STI infection among these youth.⁵ As a consequence of persistent abuse, as many as 28 percent of GLBT youth eventually drop out of school.⁶ In one survey of 500 GLBT youth of color, 46 percent reported that they had been the victims of violence from family, peers, or strangers.⁶ In another study of GLBT youth of color, 41 percent of females, and 35 percent of males had attempted suicide.⁶ Thus, it is evident that prejudice and discrimination often have an increasingly negative impact on the health of young people.

- 3) Young people face barriers and obstacles in sexual and reproductive health programs.** Culture in the United States reflects extremely ambivalent feelings about the rights of minors, especially in regard to sexuality and reproductive health care. Contradictions and age-based discrimination are clearly evident in reproductive health programs and policies. Americans want teens to be sexually responsible. Yet, Americans also design and fund programs that deny teens the information and services they need to protect themselves from unintended pregnancy or HIV/STIs. Numerous legal barriers, such as confidentiality restrictions and parental consent or notification laws, restrict teens from obtaining adequate reproductive and sexual health information and services. While all youth are negatively affected by these age-related restrictions, some youth face additional barriers posed by prejudice and discrimination. For example, lack of health insurance among the working poor can prevent teens from these families from receiving urgently needed care, such as contraception and testing and treatment for HIV and other STIs.
- 4) Teens who experience prejudice and discrimination may have less self-esteem and fewer resources and skills to meet the challenges that all teens face.** During adolescence, teens experience a variety of physical, social, cognitive, and emotional developmental changes. For high self-esteem and a strong self-concept, teens need to feel that they belong (peer identification), and they need positive role models. Research indicates that adolescents with high self-esteem are more likely to protect themselves from pregnancy and HIV/STIs, compared to teens with low self-esteem.⁷ Teens with less self-esteem may feel less effective at negotiating safer sex, communicating with peers and partners, and accessing health care.⁷ Feeling less effective can leave teens unwilling to act—unwilling to negotiate, communicate, or take other important steps to protect their health.
- 5) Media strongly influence adolescents' self-perceptions and self-concept.** Mass media, policy debates, and community programs often present an image of young people as problems. Too often, the focus is on school failure, substance use, gang violence, teen pregnancy, and/or HIV/STIs. Cultural images fluctuate from that of the uncontrollable, hard-to-reach, angry, and rebellious teen to the poor, disconnected, and distraught teen. Meanwhile, advertising builds the image of the sexy, carefree teen. What happens when adolescents repeatedly see and hear these images, internalize them, and then struggle to live into an idealized or distorted picture inconsistent with youth's true identity? For example, some young men may pop steroids to build the body they think they must have. And, researchers attribute much of young women's eating disorders to media messages that convince the individual young woman that she must be thin to have a fulfilling life.⁸

Step Two: Assess the Needs and Assets of Youth in the Community⁹

Understanding the connections between different forms of oppression and adolescent sexual and reproductive health is the first step in building effective programs. The next step requires an examination of community programs and services.

- 1) Assess the health status of youth and the accessibility of services.** Gather demographic information on youth in the community: age, gender, race/ethnicity, and family income levels, as well as health, education, and economic indicators. Assess the extent to which substance use, teen births and abortions, HIV/STI, and school failure and dropout affect different populations of youth. Evaluate teens' access to health care and social services by examining fee schedules, hours of operation, locations, the availability of public transportation, and laws and policies on confidentiality. Evaluate neighborhood environments by assessing the local availability of healthy foods and fresh produce, recreational facilities, employment opportunities, and quality health services. Involve youth and adult members of the community in the process of creating assessment tools and making decisions about assessment techniques, such as surveys, focus groups, or interviews.
- 2) Assess the cultural appropriateness of services.** Program planners must assess the environment of their organization, including management, operations, outreach, community involvement, and service delivery. This means evaluating the mission and activities of the organization; the level of cultural competence among board members, staff, and volunteers; agency policies and procedures on discrimination and harassment; staff training; whether programs are culturally appropriate and/or multicultural; and the reading levels and appropriateness of the educational materials for young people at different developmental stages.

Is the staff representative of the target population? Who conducts community outreach and how? Each staff member needs meaningful ways to examine her/his attitudes, beliefs, and knowledge in regard to adolescent sexuality and reproduction, adolescent relationships, and teen parenting. What experience influences staff's perceptions of adolescent sexual health? Does staff have biases or hold stereotypes? In what subtle or blatant ways might staff be communicating these biases to young people? The ability of staff to interact with each individual openly, flexibly, and respectfully will affect the program's success. In the end, there is no magic solution—just continuous efforts—for working effectively with diverse youth.

3) Learn about the cultural and family background, health beliefs, and religious practices of each young person in the program. Values, attitudes, and beliefs, levels of knowledge, and communication patterns about health, sexuality, relationships, contraception, and childbearing vary significantly across cultural and ethnic groups and from family to family. Tailoring programs to the cultural background(s) of participating youth can increase the program's effectiveness.¹⁰ For example, programs working with immigrant youth need to understand the cultural norms related to teen sexuality and parenting in the youth's original countries and/or communities. In some countries in sub-Saharan Africa, southern Asia, and Latin America, between 25 and 50 percent of young women have had children by age 20.^{11,12,13} Concepts like "a pregnancy-free adolescence" may resonate differently for youth immigrating from these countries than for youth raised in the United States.

4) Assess the experience and knowledge of youth in the community. Needs assessment tools and techniques typically provide statistical facts and figures on which to evaluate adolescents' behaviors and their sexual health. Focusing exclusively on objective data and trends, however, can cause adults to overlook the insights and experiences of teens and to measure teens' health solely in relation to adult standards. Finding ways to record teens' perspectives, interpretations, and viewpoints—through surveys, focus groups, and interview—can help to ensure that a program truly meets the needs of the community's youth.

Step Three: Empower Youth and Offer Culturally Competent Programs in the Community

Information from the needs assessment will help inform the design, operations, and continuous improvement of programs. Planners can use the information from the needs assessment to develop strategies that will empower teens and ensure that programs are culturally appropriate.

1) Support peer education and the leadership of youth. Adolescent health professionals increasingly recognize the powerful effect that teens exert when they speak out for themselves, define the issues that matter to them, and craft an agenda to address those issues. Youth can create initiatives that address inequities and disparities in health care, drawing upon other social movements, such as civil rights, women's rights, and HIV/AIDS activism. For example, the civil rights movement challenged *separate but equal* as being inherently racist. Is *separate but equal* applied today to adolescents? What rights do minors share with adults? What rights do they not share? Young people could use *consciousness-raising*—a term from the turbulent 1960's and 1970's in the United States—to explore attitudes and beliefs among today's youth and to raise concerned awareness of youth's social issues. *Consciousness-raising* is distinctly different from educational sessions where adults teach, and young people learn, specific skills and knowledge. Or, youth might utilize *I have a dream* to envision their future. These types of work focus attention on the assets, contributions, strengths, and skills of young people.

2) Create opportunities for youth to talk openly and frankly about racism, sexism, homophobia, class discrimination, and other forms of oppression. Programs should offer a safe environment where teens can feel comfortable talking about individual identity, experiences, hopes, and fears. Teens need to feel and understand how they and others have experienced prejudice and discrimination. Interactive and experiential exercises, such as case studies and role-playing, can help teens think through the barriers and obstacles that oppression creates. For example, youth can better understand gender discrimination by exploring how ideas about gender roles limit young people's growth and future and how gender role stereotypes can damage relationships. Or, youth might explore economic issues by analyzing the costs and benefits to a teen with little money of spending his/her allowance or hard-earned dollars on condoms. Role-playing can allow youth to experience how someone of a different race/ethnicity might feel at a clinic staffed only by clinicians and counselors of a different racial/ethnic background. In this way, activities can frame reproductive and sexual health decisions within the overall context of adolescents' lives and help teens to understand how oppression affects them and others.

3) Replicate and adapt HIV/STI and pregnancy prevention programs that have been evaluated and shown to achieve positive outcomes for young women, youth of color, low-income youth, and/or GLBT youth. A number of strategies and programs have been proven to work at the community level to influence sexual risk behaviors. These include sex education that includes messages about both abstinence and contraception; contraceptive and condom availability programs; and youth development programs that offer mentoring, community service, tutoring, and employment training.¹⁴ Planners should culturally adapt research-based, scientifically evaluated programs for the community's youth.*

4) Ensure that prevention efforts are culturally specific. Many extant programs are culturally specific. For example, *The Valley*, in New York City, provides multicultural education for young people from diverse backgrounds through its *Circle of Sistahs*

program. *Circle of Sistahs* uses internships to encourage young women of color to develop positive relationships with adult women of color. *The City* in Minneapolis draws on specific cultural traditions to address teen pregnancy, drug abuse, academic problems, and violence. One of its programs, *Ni'Uhura* (Healing is Freedom), is designed specifically for African American youth and another, *Oshki-Bug* (New Leaf), is designed specifically for American Indian youth. *The Latin American Youth Center*, in Washington, DC, recognizes that immigration status, acculturation, health beliefs, and family and religious background influence young people's reproductive and sexual health decisions. *SMYAL* and *Metro Teen AIDS*, both in Washington, DC, and *Hetrick-Martin Institute* in New York City, offer direct services to GLBT youth.

In conclusion, programs must recognize and deal with the broad social, economic, and political framework within which teens live. Program planners must ensure that services are both culturally appropriate for and also friendly to young people. Focusing on the young people's right to information and services can also empower young people to demand honest, accurate, culturally relevant information and unrestricted access to health services. Empowering youth can encourage adolescents to take responsibility for their own reproductive and sexual health and to envision their own future.

* For information on evaluated programs, contact Advocates for Youth or visit www.advocatesforyouth.org/programsthatwork/

References

- ¹ Ozer EM, Brindis CD, Millstein SG, et al. *America's Adolescents: Are They Healthy?* San Francisco, CA: National Adolescent Health Information Center, School of Medicine, University of California, 1997.
- ² Moore KA, Miller BC, Gleit D, et al. *Adolescent Sex, Contraception, and Childbearing: a Review of Recent Research*. Washington, DC: Child Trends, 1995.
- ³ The three-step model presented in this paper is adapted from: Messina M. *A Youth Leaders' Guide to Building Cultural Competence*. Washington, DC: Advocates for Youth, 1994.
- ⁴ Center for Reproductive Law and Policy. *Exposing Inequity: Failures of Reproductive Health Policy in the United States*. New York: The Center, 1998.
- ⁵ Earls M. *Lesbian, Gay, Bisexual, and Transgender Youth: At Risk and Underserved*. [The Facts] Washington, DC: Advocates for Youth, 2003.
- ⁶ Savin-Williams RC. Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: associations with school problems, running away, substance abuse, prostitution, and suicide. *Consulting & Clinical Psychology* 1994; 62:261-269.
- ⁷ Holmbeck GN, Crossman RE, Wandrei ML, et al. Cognitive development, egocentrism, self-esteem, and adolescent contraceptive knowledge, attitudes, and behavior. *Journal of Youth & Adolescence* 1994; 23:169-193.
- ⁸ Worcester N, Whatley MH, ed. *Women's Health: Readings on Social, Economic, and Political Issues*. 2nd ed. Dubuque, IA: Kenall/Hunt, 1994.
- ⁹ The assessment information presented here is largely drawn from: Brindis CD, Davis LD. *Building Strong Foundations, Ensuring the Future*. [Communities Responding to the Challenge of Adolescent Pregnancy Prevention, v. 2] Washington, DC: Advocates for Youth, 1998.
- ¹⁰ Moore KA, Sugland BW. *Approaches to Preventing Adolescent Childbearing: Next Steps*. Washington, DC: Child Trends, 1995.
- ¹¹ Alan Guttmacher Institute. *Women and Reproductive Health in Latin America and the Caribbean*. New York: The Institute, 1994.
- ¹² Alan Guttmacher Institute. *Women and Reproductive Health in North Africa and the Middle East, and in Asia*. New York: The Institute, 1994.
- ¹³ Alan Guttmacher Institute. *Women and Reproductive Health in Sub-Saharan Africa*. New York: The Institute, 1994.
- ¹⁴ Alford S et al. *Science and Success: Sex Education and Other Programs that Work to Prevent Teen Pregnancy, HIV and Sexually Transmitted Infections*. Washington, DC: Advocates for Youth, 2003.