ISSUES AT A GLANCE

Adolescent Sexual Health and the Dynamics of Oppression

A Call for Cultural Competency

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 demonstrates the relationship between socioeconomic factors[1] —such as poverty, family distress, sexual networks[2], and access to health care as well as the impact of race/ethnicity, being young[3], gender (including young men)[4], class, and/or perceived sexual orientation[5] on negative health outcomes.

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 developing and implementing 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 PEOPLE

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.[6] 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.[6] 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.[6]

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.

African Americans suffer from negative sexual health outcomes at greatly disproportionate rates, with young women and young men who have sex with men particularly at risk.[7,8] A common misconception is that young African Americans simply are not as careful as whites in protecting their sexual and reproductive health – but studies have shown that even with equal or fewer sexual risk behaviors, African Americans/Blacks are more at risk. An individual's risk is not solely a result of personal risk behavior, but is also a function of the "pool" of disease in their sexual network.[9] Poverty, unemployment, unstable neighborhoods, and unequal rates of incarceration all contribute to unequal access to health care and raise a young person's risk of contracting HIV or an STI.[10]

Research also demonstrates that institutionalized homophobia results in high rates of violence toward GLBT youth in schools and communities. The Gay, Lesbian and Straight Education Network's (GLSEN) 2007 report on the experiences of gay, lesbian, bisexual and transgender (GLBT) students surveyed 6,209 middle and high school students and found that nearly 9 out of 10 GLBT students (86.2 percent) experienced harassment at school in the past year, three-fifths (60.8 percent) felt unsafe at school because of their sexual orientation and about a third (32.7 percent) skipped a day of school in the past month because of feeling unsafe.[11] Service providers estimate that 25 to 40 percent of homeless youth may be GLBT.[12] According to one study, 50 percent of gay teens experienced a negative reaction from their parents when they came out and 26 percent were kicked out of their home.[13]

Thus, it is evident that prejudice and discrimination often have an increasingly negative impact on the health of young people — with young people who are members of more than one minority group facing even greater challenges.

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Prejudice and discrimination, at individual and institutional levels, contribute to negative sexual health outcomes among 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 develop 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. Immigrant youth face additional barriers as well due to lack of culturally and linguistically appropriate services.

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 condom use self-efficacy, optimism about the future, and reported behavior change attributable to HIV/AIDS are significant predictors of condom use at most recent intercourse.[14] Teens with less self-esteem may feel less effective at negotiating safer sex, communicating with peers and partners, and accessing health care. Feeling less effective can leave teens unwilling to act—unwilling to negotiate, communicate, or take other important steps to protect their health. For example, one study among GLBT people found that young adults were one of the groups with disadvantaged social well-being. This study also suggested that these conditions can be mediated by a sense of positive community connectedness.[15]

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, Many GLBT youth report relying on television to learn what it means to be lesbian or gay. In one study, 80 percent of these youth ages 14 to 17 believed media stereotypes that depicted gay men as effeminate and lesbians as masculine. Half believed that all homosexual people were unhappy.[13]

STEP TWO: ASSESS THE NEEDS AND ASSETS OF YOUTH IN THE COMMUNITY

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 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.

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 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.

Effective programs value diversity and address behavioral, cultural, and institutional barriers which negatively impact young people's health.

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.[16] Planners should culturally adapt evidence-based programs for the community's youth.*

4) Ensure that prevention efforts are culturally specific. Youth-serving organizations are most successful when their programs and services are respectful of the cultural beliefs and practices of the youth they serve. A culturally competent program values diversity, conducts self-assessment, addresses issues that arise when different cultures interact, acquires and institutionalizes cultural knowledge, and adapts to the cultures of the individuals and communities served. This may mean providing an environment in which youth from diverse cultural and ethnic backgrounds feel comfortable discussing culturally derived health beliefs and sharing their cultural practices. Creating culturally competent programs is not difficult, but it requires conscientious attention and the understanding that it is a life long process of learning and adaptation.

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

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