Talking to African-American Teens About Sex

Danielle Hartwig, MD

The reduction in teen pregnancy rates in the last 27 years since its peak in 1991 has been a marked success in public health. Wisconsin has one of the lowest teen pregnancy rates in the country, a triumph of increased contraceptive use by teens. A closer look at the data, however, reveals severe racial disparities. Of the 31 states that choose to report data stratified by race, Wisconsin has the fourth-lowest rate of teen pregnancy among white teenagers and the fourth-lowest rate overall. However, for African-American teens specifically, Wisconsin ranks an appalling 27th out of those 31 states.[1] Clearly, there is essential work to be done to provide better reproductive care and education for young African-American men and women. Delivering comprehensive and accessible sex education for African-American teens requires not only quality teaching in schools, but in communities and clinics as well.

Wisconsin law currently does not require public schools to teach sex education. If a school chooses to do so, the curriculum does not explicitly require information about contraceptives, nor does it have a requirement for the age at which the education occurs, the duration of the education, or who provides it. This policy means that the quality and content of sex education that Wisconsin students receive—if any—varies widely from school to school. Furthermore, curricula that are in place often are biased, favoring sex within heterosexual married couples, a situation that is not reflective of the reality of many African-American teenagers who commonly see single and teenage parents in their communities and homes. A more inclusive and comprehensive curriculum would be more relevant for populations that do not fit this narrow mold. Moreover, approaching sex education from the lens of building healthy relationships, both physically and emotionally, removes the shame and fear inherent to many of the current curricula.

While improving the quality of sex education provided in schools would aid all students, the African-American student population would perhaps benefit even more through additional initiatives. Community-based efforts are likely to better serve this demographic, which may have a historical distrust of the medical system. In particular, peer-to-peer education makes information more accessible to teens who may not receive adequate education at school or at home. The RIPPLE study demonstrated that peer-educated teens in the United Kingdom had fewer self-reported pregnancies by age 18 when compared to teens who received teacher-led sex education.[2] Training teens to be advocates for their own sexual health and wellness improves the chance that the information being spread within the community is accurate and complete. Additionally, holding community workshops where teens and parents can learn together in a familiar, nonclinical environment ensures that parents are also educated and are able to share appropriate information with their children. Improving the availability and visibility of educated community members who may be perceived as more approachable than clinicians—and who have more thorough information than schools—will better serve the most vulnerable members of the African-American population.

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In addition to advocating for more comprehensive sex education in schools and greater support of community-based programs, physicians can also make changes in how they talk to teenage patients about sex. African-American teens may feel judged or stereotyped when their physician asks them about sex. This is particularly true when the subject is broached by a physician of a different race, culture, or sex. African-American patients tend to have greater satisfaction with their care if their physician is race-concordant,[3] and likewise tend to rate race-discordant physicians lower the more measured implicit bias the physician has against African-Americans.[4]

Normalizing the conversation about sex and approaching it in an unbiased manner is important to create a safe and comfortable space for every patient to ask questions. Spending a few minutes alone with teenage patients at every visit—even acute care appointments—optimizes opportunities to discuss sensitive topics, especially for patients who may not present for routine care. Making conversations about healthy peer relationships a routine part of visits with young children makes the transition to having conversations about sexual relationships when they are older more fluid. It also allows the clinician to establish a trusting relationship with the patient early on so that they feel more comfortable approaching their clinician with questions about sex-related topics when they arise. Finally, framing the discussion around the teen's goals and expectations for their life, both now and in the future, allows the clinician to form a partnership with the patient, gives the patient more autonomy over their health care decisions, and may help elucidate long-term direction for the teen. The American Academy of Pediatrics has published a detailed report outlining the appropriate and most effective ways to address these topics in the adolescent population.[5]

While changing the curriculum of sex education in schools and improving accessibility to community-based programs will require substantial effort and motivation from multiple agencies, making meaningful changes in how clinicians talk to their African-American teen patients can begin to reduce the disparity in the teenage pregnancy rate in this population.

Acknowledgements: Special thanks to Dipesh Navsaria, MD, and Kristi F. Jones MPH, CHES, for their assistance and support.

Funding/Support: None declared.

Financial Disclosures: None declared.

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