

Communication and Information About “Safer Sex”: Intervention Issues Within Communities of African Migrants Living in Poorer Neighborhoods in Portugal

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ABSTRACT. The aims of this study are to determine the influence of migrant status on sexual behavior and communication about “safer sex”

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and to identify ethnic-specific prevention issues. Data were obtained from a special administration of the Health Behavior in School-Aged Children (HBSC) survey in a special sample of Portuguese schools located in low-income Lisbon neighborhoods with large proportions of African migrants. Survey participants included 919 sixth, eighth, and tenth graders (52.3% female), of whom 19.2% were migrant foreigners from African, Portuguese-speaking countries, including Cape Verde (60.8%), Mozambique (1.6%), Angola (16.8%), Sao Tomé (8%), and Guinea-Bissau (14.8%). Subsequently, four focus groups were held with adolescents who had participated in the survey ($n = 45$), three focus groups with health and education professionals ($n = 25$), and one focus group with parents ($n = 6$).

Compared with Portuguese adolescents, African migrant teens reported initial sexual intercourse at earlier ages, less frequent condom use, and less frequent and less comfortable communications with parents about sexual issues.

Implications for selective prevention of sexually transmitted diseases (STDs) are discussed and recommendations are made.

KEYWORDS. Communication, information, HIV prevention, poverty, ethnicity, sexual risk.

COMMUNICATION AND INFORMATION ABOUT “SAFER SEX”: INTERVENTION ISSUES WITHIN COMMUNITIES OF AFRICAN MIGRANTS LIVING IN POORER NEIGHBORHOODS IN PORTUGAL

Portugal has long been known as a society of immigrants. The arrival of large numbers of immigrants from Africa, and lately from Brazil and East European countries, has increased the multicultural population of Portuguese schools, providing new educational challenges.

The Health Behavior in School-Aged Children (HBSC) survey, a World Health Organization (WHO) collaborative study (HBSC/WHO) (Currie et al., 2000; Matos, Gaspar, & Equipa do Projecto Aventura Social & Saúde, 2003) conducted in Portugal in 2002, concluded that migrant African adolescents, compared with native Portuguese adolescents, reported more risk behaviors, less healthy lifestyles, poorer relationship in social contexts (family, school, and community), and greater substance use (alcohol and drugs). Migrant African youth were also more often involved in fights and violent acts, less involved in school, had lower school performance, and were less happy. Moreover,

African adolescents were more likely to have sexual intercourse, unprotected sex, and sex associated with alcohol and drug use. Finally, they reported poorer communication with parents.

However, many of these differences were no longer significant when socioeconomic status (SES) was considered. The associations between migrant status and poor health, lower well-being, school failure, family communication, and behavior problems were fully mediated by poverty and were no longer present when comparing groups with the same SES. The only significant differences between migrant adolescents and other Portuguese adolescents with similar SES were related to sexual behavior (Gaspar, Matos, & Gonçalves, 2005; Matos, 2005; Matos & Gaspar, 2003; Matos et al., 2003; Matos, Gaspar, & Gonçalves, 2004; Matos, Gonçalves, & Gaspar, 2005).

Many migrants from Portuguese-speaking African countries (i.e., Cape Verde, Mozambique, Angola, Sao Tomé, Guinea-Bissau) live in poor neighborhoods, often illegally, under poor social and economic conditions. Young migrants are exposed to the different cultures and social patterns of their home country and of Portugal. Lifestyle and access to health and education are limited by poverty. Adolescents of low SES present more psychological symptoms and report less social support (Gaspar, 2005; Muuss & Porton, 1999), more health problems, poorer reading skills, and lower school attendance and performance. African migrants tend to marry young and have children early, a trend that is associated with school drop out and a lifetime of lower-paying work, frequent periods of unemployment, and socially deviant behavior (Matos et al., 2005).

Gender relationships among African migrants typically are not equitable, with males tending to dominate, with consequences in terms for sexual health. Previous research has shown that African men make the decision about condom use, often resist use, and sometimes believe that being asked to use a condom indicates infidelity (Kahssay & Oakley, 1999; Matos et al., 2005; Matos, 2005; Muuss & Porton, 1999; Muza & Costa, 2002).

Health programs to address the unique problems faced by African migrant adolescents are needed. Programs may be more effective if they are culturally tailored (Elifson, Klein, & Sterk, 2006; Gaspar, 2005) and include personal and social skills programs to reduce health risks and promote healthier lifestyles and happier perceptions of life (Kahssay & Oakley, 1999; Muuss & Porton, 1999; Muza & Costa, 2002; Whitaker & Miller, 2000; Williams, Holmbeck, & Greenley, 2002). Programs should also focus on the specific sexual health concerns of condom nonuse, short duration of relationships, and multiple partners. Previous studies reported

communication problems between parents and children, particularly about sexuality, including sexual behavior and sexual transmitted infections (STIs) and HIV prevention, particularly among adolescents with an African background (Muuss & Porton, 1999; Williams et al. 2002).

To gain a better understanding of migrant African adolescent attitudes regarding safer sex issues, a special sample of schools from the Lisbon suburbs with high concentrations of African migrants was drawn. The purpose of this study was to examine the sex risk attitudes and behavior of migrant African adolescents. Specifically, a special survey of low-income schools with high proportions of migrant African youth and focus groups were conducted, and the data were analyzed to (1) gain a better understanding of migrant adolescents' sexual behaviors, (2) assess preferred resources to obtain information about sex issues, and (3) determine how best to support migrant adolescents in choosing and maintaining safer sexual behaviors.

METHODS

Participants and Sampling

The study used survey and focus group data. First, the HBSC survey was conducted and questions about family and peer communication, socio-economic issues, and sexual behavior were analyzed. Second, focus groups were conducted with adolescents, parents, and health and education professionals to provide additional information about these topics and about related programmatic needs.

Survey

The data for the present study was obtained from a special HBSC survey conducted in a sample of Lisbon-area schools that were not part of the 2005 Portuguese national HBSC (Gaspar et al., 2005; Matos et al., 2005). The same national team carried out both the national survey and this specific survey. Schools located in low-income suburbs of Lisbon with high concentrations of African migrants were selected for the survey. Eligible schools and classes were randomly selected. Apart from the specific characteristic of the target population, no major sampling bias was expected. Questionnaires were answered anonymously and on a voluntary basis. The study was sponsored by the Portuguese Foundation of Science and Technology (FCT), and approved by the Scientific Councils of the University and Centro da Malária e Doenças Tropicais (research center). Authorization was obtained from

schools' principals, and informed consent was obtained from parents through the Pedagogical Council. No refusals to participate were registered.

The survey included questions concerning demographics (age, gender, nationality), health and social support, sexual behavior, resources used for getting information about safer sex issues, and communication about sex issues and HIV prevention. Variables and questions are shown in Table 1.

Sample. The special sample included 919 sixth, eighth, and tenth graders from low-income Lisbon suburbs ($M = 14.4$ years old, $SD = 2.1$), 52.3% of whom were female and 19.2% of whom were migrant foreigners from African, Portuguese-speaking countries: Cape Verde (60.8%), Mozambique (1.6%), Angola (16.8%), Sao Tomé (8%), and Guinea-Bissau (14.8%). Table 2 shows the frequencies of selected socioeconomic and cultural indicators for the most recent HBSC/WHO national study (Matos & Aventura Social Team, 2006) carried out in 2006 ($N = 4877$) and for the special Lisbon area sample ($N = 919$). The last column includes only the subgroup of migrants from African Portuguese-speaking countries from the special Lisbon area sample of schools ($N = 176$). The frequencies indicate that the target areas are poorer than the rest of the country, and that within those areas, migrant adolescents experience lower SES and unique family conditions. Among those migrant adolescents, 42.2% did not speak Portuguese at

TABLE 1. Variables derived from HBSC/WHO survey, used in the special lisbon area low-income school sample

Variables	Range
1–Nationality Recoded : Portuguese (1) African background (2)	Question “nationality” with six alternatives 1 (Portugal), 2 (Cape Verde), 3 (Mozambique), 4 (Angola), 5 (Sao Tomé), and 6 (Guinea-Bissau)
2–Sexual intercourse (SI)	Question “had sexual intercourse” rated 1 (yes) to 2 (no)
3–Condom use	Question “condom use last SI” rated 1 (yes) to 2 (no)
4–Sources of Information about HIV (Brochures/Parents)	Question “sources of information about HIV and other STI” rated 1 (yes), 2 (No) and 3 (maybe)
5–Feel uncomfortable to talk with friends (same age) about HIV	Question “how do you feel talking with people the same age as you about HIV” rated 1 (comfortable) 2 uncomfortable 3 (do not talk about this with them)
6–Feel uncomfortable to talk with parents about HIV	Question “how do you feel talking with parents about HIV” rated 1 (comfortable) 2 uncomfortable 3 (do not talk about this with them)

TABLE 2. General characterization of the national sample (Portuguese national Survey HBSC/WHO, 2006) and special lisbon area school sample

	National Portuguese HBSC Sample, 2006 (N = 4877)(%) ¹	Lisbon Area Special Sample (N = 919)(%)	African Migrants From the Lisbon Area Special Sample(N = 176)(%)
1– Migrant status (% Yes)	2.2	19.2	100
2– Father unemployment (% Yes)	7.1	10	13.8
3– Father SES(lower condition in a 5-point national scale characterization)	14.9	24.3	40.2
4–Father education (% never studied)	2.2	6	10.8
5–Do not have or do not see father	5	14.2	15.1
6– Mother unemployment (% Yes)	24.4*	18.9	23.2
7– Mother SES(lower condition in a 5-point national scale characterization)	35.1	46.5	67.2
8–Mother education (% never studied)	1.7	8.4	20.3
9–Do not have or do not see mother	2.1	4.5	5.4
10– Self perception of poor SES	10	17	33.3
11– Do not speak Portuguese at home	1.6	12.6	42.2
12– Reports always going to bed hungry	0.7	1.4	2.4

*4.2% looking for a job; 56.9% working “at home”.

¹Matos & Aventura Social Team, 2006.

home. Using a 5-point scale, where 5 corresponds to an “extremely low” socioprofessional level, 14.9% of adolescents from the Portuguese national survey reported their father’s situation as such, whereas 24.3% adolescents in this specific sample assessed their father’s current job as belonging to this group, and in the subgroup of African migrant adolescents, 40.2% assessed as such: $\chi^2(5, N=919)=16.65, p < 0.05$.

Survey Data Analyses. Bivariate analyses (chi-square tests, $p < 0.05$) of the survey data were used to calculate unadjusted associations between Portuguese adolescents and African migrant adolescents participating in the special Lisbon area sample. The outcome variables were sexual behavior, resources used to get information about safer sex and HIV prevention, and communication about HIV prevention.

Logistic regression analyses were carried out to examine associations between sexual intercourse from gender, age, nationality, and communication with friends and peers about HIV prevention. Subsequent analyses included only adolescents who had already had sexual intercourse to examine associations between the same independent variables and the use of condom at last sexual intercourse.

Focus Groups

Focus groups were carried out in the same communities and included four groups of adolescents ($n=45$), three groups of health and education professionals ($n=25$), and a group of parents ($n=6$). For these groups adolescents 13 to 16 years old were recruited from the schools where the survey was carried out, professionals were recruited from the staff of the schools or youth centers in the neighborhood, and parents were recruited during academic meetings at the participating schools. In all cases, a special announcement was made in the schools calling for participation in “a group discussion about health and health topics with a health expert.”

The primary aim of the focus groups was to identify the different views and opinions on health and subjective well-being by promoting an opportunity for adolescents, parents, and health and education professionals to explore these ideas. A researcher met the participants prior to the focus groups to present the aims of the study, attain consent, and generally organize the day of the focus group. Each of the eight focus groups took 60 to 90 minutes. Participants met in groups around a table. Discussions were tape recorded for later transcription. A puppet was used as an ice breaker, followed by a brief general discussion and introduction. The focus group followed the methodology proposed by Morgan, Krueger, and King (1998). The prestructured questions related to sexual behavior included in the focus groups are shown in Table 3.

The focus groups were conducted by two Portuguese health research psychologists, authors of this paper, who have extensive experience running focus with minorities. It was not possible in this

TABLE 3. Prestructured questions related with sexual behaviors included in the focus groups

Pupils	1– Do you think that you have enough information about sexuality and safe sex? 2–Who, or what, is your main source of information? 3–What are the communication or information access barriers?
Parents	1–Do you consider your children informed about sexuality and safe sex? 2–Who, or what, are their main sources of information? 3–What are the communication or information access barriers?
Professionals	1–In general, do you consider your pupils informed about sexuality and safe sex? 2–Who, or what, are their main sources of information? 3–What are the main communication or information access barriers?

study to have facilitators who were similar to participants (Lambert, Hublet, Verduyck, Maes, & Broucke, 2002). During the focus groups, the researchers introduced a few themes related to health behaviors, including sexual behavior, violence, and substance use. The facilitator followed a prestructured sequence of questions, but allowed a free flow of conversation.

The researchers independently read the transcripts and classified them into themes and categories, according to the prestructured interview frame, which was based on the results of HBSC Portuguese national study and on reviewed literature. An agreement was reached on the overriding themes from both the raw speeches and the prestructured framework, and illustrative quotes were identified.

RESULTS

Analyses of the survey data indicated that migrant foreign adolescents with African background, compared with other Portuguese adolescents, had sexual intercourse more often and used condoms less frequently. Moreover, African youth were more likely to get information about STI and HIV from brochures than parents. In comparison, Portuguese adolescents, even those living in such deprived socioeconomic areas, were less prone to sexual risk behavior and were more likely to obtain information about sex from parents than print materials. African migrant pupils were more likely to report being uncomfortable talking with parents about

TABLE 4. Comparisons between portuguese adolescents and adolescents with African background, (N = 919)

	African Migrant N = 743 (%)	Portuguese N = 176 (%)	χ^2	df	Sig.
1–Had sexual intercourse	68.6	27.8	130.33	1	0.000
2–Used condom	51.2	70.4	14.03	1	0.000
3–Sources of Information about HIV (Brochures/ Parents)	76.9	72.7	7.98	2	0.019
4–Feel uncomfortable to talk with friends (same age) about HIV	41.4	60.1	25.96	2	0.000
5–Feel uncomfortable to talk with parents about HIV	15.0	16.2	0.207	2	0.207(n.s.)
	33.7	26.9	36.58	2	0.000

HIV. All chi-square tests revealed significantly different distributions ($p < 0.05$), as seen in Table 4.

First Sexual Intercourse

A logistic regression model was carried out to identify associations with sexual intercourse from gender and age group (groups 11 to 17 years old). In the first step, the model explained 42.6% of the variance (Nagelkerke $R^2 = 0.426$). The Hosmer and Lemeshow Test for the model of fit showed that the model fits the data well [$\chi^2(7, N = 873) = 9.278, p = 0.233$]. After Step 1, the success rate for “predicting” a sexual relationship was 77.2%. Males were 6 times as likely to have already initiated sexual relationships [OR 5.985; 95% CI (4.091–8.754); $p = 0.000$]. Sexual initiation increased significantly with age. Compared with 11-year-old adolescents (reference value), 14-year-olds were 8 times as likely to have initiated sexual relationships, [OR 8.077; 95% CI (2.656–24.567); $p = 0.000$], 15-year-olds were 13.5 times more likely to have initiated sexual relationships [OR 13.58; 95% CI (4.555–40.486); $p = 0.000$], 16-year-olds were 18.5 times more likely to have initiated sexual relationships [OR 18.641; 95% CI (6.246–55.631); $p = 0.000$], and 17-year-olds were 49 times more likely to have initiated sexual relationships [OR 49.211; 95% CI (16.221–149.298); $p = 0.001$]. African migrants were 2.9 as likely to have had sexual intercourse compared to non-migrant adolescents in this sample [OR 2.933; 95% CI (1.928–4.461); $p = 0.000$].

“Uncomfortable communication with parents” and “uncomfortable communication with peers” about HIV prevention, when added as a predictor in the first step of the model, explained 43.3% of the variance (Nagelkerke $R^2 = 0.433$). The Hosmer and Lemeshow Test for the model of fit showed that the model fit the data well [$\chi^2(8, N = 855) = 9.672, p = .289$]. After Step 1, the success rate for “predicting” a sexual relationship was 77.5%. Nevertheless, the increase in explained variance (0.7%) and the increase in the success in prediction (0.3%) were not significant ($p = 0.878$ for friends and $p = 0.221$ for parents) and were therefore excluded from the final model (see Table 5).

Condom Use at Last Intercourse

Within the group of youths already sexually active, a logistic regression model was carried out to identify associations with condom usage at last intercourse based on gender, age group (groups 11 to 17 years old), nationality, and “uncomfortable communication with parents” and “uncomfortable communication with peers” about HIV prevention. In the first step, the model explained 15.1% of the variance (Nagelkerke $R^2 = 0.151$). The Hosmer and Lemeshow Test for the model of fit showed that the model fit the data well [$\chi^2(8, N=276) = 7.979, p = 0.436$]. After Step 1,

TABLE 5. Predictors of first sexual intercourse

	Odds Ratio	Confidence Interval (95 %)	p
First Sexual Intercourse			
Gender			
Female	1.000		
Male	5.985	4.091–8.754	0.000
Age Group			
11-year-old	1.000		
12-year-old	1.457	0.401–5.295	0.568
13-year-old	2.914	0.938–9.054	0.065
14-year-old	8.077	2.656–24.567	0.000
15-year-old	13.58	4.555–40.486	0.000
16-year-old	18.641	6.246–55.631	0.000
17-year-old	49.211	16.221–149.298	0.000
Nationality			
Portuguese	1.000		
African migrant	2.933	1.928–4.461	0.000

TABLE 6. Predictors for the use of the condom in the last intercourse

	Odds Ratio	Confidence Interval (95%)	p
Use of the Condom in the Last Intercourse			
Gender			0.096 (n.s.)
Age group			0.387 (n.s.)
Nationality			
Portuguese	1.000		
African migrant	2.493	1.395–4.455	0.002
Uncomfortable communication about HIV prevention			
Peers	0.522	0.345–790	0.002
Uncomfortable communication about HIV prevention			
Parents			0.507 (n.s.)

the success rate for prediction of condom use in the last instance of sexual intercourse was 68.5%. Age and gender were not significant predictors of using condoms ($p = 0.096$ for gender and $p = 0.387$ for age).

Compared with other Portuguese adolescents, African migrant adolescents were 2.5 times more likely to have not used a condom in their most recent instance of sexual intercourse [$OR\ 2.493$; 95% $CI\ (1.395–4.455)$; $p = 0.002$]. Adolescents who didn't talk to friends about HIV transmission were less likely to have used a condom at last sexual intercourse [$OR\ .522$; 95% $CI\ (.345–790)$; $p = .002$]. Not talking with parents was not a significant predictor ($p = .507$) of condom use at last intercourse (see Table 6).

Qualitative Study

For the qualitative portion of this study, a summary of the most important contributions from adolescents, parents, and professional focus groups was created from the content analysis. Illustrative examples of the content are presented to illustrate the typical themes or ideas expressed by the participants. Examples of participant quotes are included in Table 7.

Adolescents' Focus Group

During focus groups, African migrant adolescents confirmed their difficulties in negotiating sexual initiation and condom usage. They

TABLE 7. Selected focus group comments by sample and topic

Focus Groups with Youth

1. Sources of information about sex.

"It is difficult talking about sex issues and school addresses the problem poorly."

"Sexual education in school is so old fashioned; they only talk about what everyone already knows."

"We find more information in the Internet than with friends or parents, and it is always available and private."

2. Talking with parents:

"These (sexual behavior and AIDS) are not issues that we can speak about at home; I don't even know him [my father]; my mother would not speak to me about sex, she would only tell me not to ruin my life and to be careful, and that's all."

"I cannot imagine myself at home, talking with my parents about AIDS."

"I think parents know much less about sex than us; we can teach them."

3. Male dominance and attitudes toward condom use:

"Getting informed and getting protection is a female business: Girls should take care."

"Girls accept doing it because they love the guy and do not want to lose him."

"In our culture every man has more than one girlfriend. If she does not accept sexual intercourse without condom, some other girl won't mind."

"I would use condom only if I do not know the girl."

"I never use condoms. I do not like them. I only go to bed with a girl when I know her."

"Condoms take away men's pleasure."

"I am unable to buy condoms; I feel really ashamed."

"Using a condom in the middle of an intercourse? It is really a lack of trust."

"When I see a girl carrying a condom, I know what she expects from me."

3. Girls attitudes toward pregnancy

"Her sister got pregnant, and her parents got angry; then the parents saw the baby and they [fell] in love with it. Her sister could leave school, and everyone was happy. Then she decided that she could also get pregnant and get rid of school."

"Parents will be angry but only for a short time...and then they are happy, and it is much better to have a baby, than to be attending school."

"My father would hit me, and my mother would make me find a job."

"I am an adolescent father. I have two daughters, one is 6 years old and the other is 1. I was very afraid the first time, but my mother did not allow us to 'stop whatever was already done.'"

"The girls get pregnant if they love the guy, but then when the girls get pregnant, the boys leave them alone."

4. Sex education in schools:

"There is something that I really don't know: Can we get pregnant everyday?"

"If condoms can get spoiled with fingernails; how can we be sure they are OK?"

Focus Groups With Professionals

1. Effective practices

"Movies that promote debates attract both parents and adolescents, and it is easier to talk afterwards."

"We initiated a 'school for parents' in order to help parents deal with their children's sexual doubts."

(Continued)

TABLE 7. (continued)

"We found useful to train a few adolescents to 'peer educate' the others; they are closer, they can really be where they are more useful."

"The youth center has a lot of facilities; they come for sports and to use computers, and we can reach them and talk about sexual health protection."

The older adolescents can be kind of a bridge to the new ones."

2. Cultural issues:

"Boys do not allow their girlfriends in the youth center; it has quite a bad reputation for girls."

"Here, the richness of a marriage and the usefulness of a wife is related to the number of births."

"Most of the young adolescents in this neighborhood have already one or two children."

"Most of these girls that have early births do not have a life project, do not go to school, do not have a job."

"Here you are really a nobody until you have a baby; and if you are 20 years old...you are just too old."

"They never mention AIDS; if someone is infected they would say – he/she) has 'it,' 'The disease'...without further comments."

"Those who attend school can get information about sex and sexual health, and they also have Youth or Health cabinets there, but the more at a risk adolescents are those who no longer go to school."

Focus Groups with Parents

"Sexuality is taboo ... it is something one does but does not talk about."

"I try to talk to her, and she says that I am old-fashioned and that she knows better"

"They already know everything. They have the school and the Internet."

"He told me that he understands everything, and that I am the one who does not understand anything."

reported difficulty talking about sexual issues, especially with parents, and, consequently, did not feel well-informed. Adolescents reported getting information mostly from the Internet and by talking with friends. They reported sexual education in schools as weak and insufficient. For example, adolescents reported the following: "We find more information in the Internet than with friends or parents, and it is always available and private."

Adolescents stated that it is difficult to talk with parents and that parents know little about sex. For example, "I cannot imagine myself at home, talking with my parents about AIDS."

Adolescents noted distinct gender differences, gender prejudice, cultural characteristics, and emotional reasons when talking about sexual intercourse and barriers to condom use. For example, "In our culture every man has more than one girlfriend. If she does not accept sexual intercourse without condom, some other girl won't mind."

Pregnancy during adolescence was an important theme to adolescents, who indicated that pregnancy could be a way to promote self-worth and social standing, particularly among girls with low school results. For example, "Parents will be angry but only for a short time...and then they are happy, and it is much better to have a baby, than to be attending school."

Although sex education has been mandatory in Portuguese schools since 2005 for students 6 to 15 years old, adolescents indicated that some of the information they received was inaccurate or inadequate. For example: "There is something that I really don't know: Can we get pregnant everyday?"

Focus Groups with Professionals. Professionals discussed cultural barriers to effective community-based interventions to prevent unsafe sex. They highlighted some effective practices based on their work with parents and peers: "We initiated a 'school for parents' in order to help parents deal with their children's sexual doubts."

Professionals felt that cultural barriers could be risk factors to community intervention with adolescents and their families: "Those who attend school can get information about sex and sexual health, and they also have Youth or Health cabinets there, but the more at a risk adolescents are those who no longer go to school."

Parent focus groups. Parents confirmed that it is difficult to talk with their children, and that they feel insecure, powerless, and even hopeless when it comes to helping them: "He told me that he understands everything, and that I am the one who does not understand anything."

DISCUSSION

The results confirm previous research that indicates that African migrant adolescents are at high risk for unsafe sex in that they use condoms infrequently and lack sufficient communication with parents (Gaspar, Matos, & Gonçalves, 2005; Matos, 2005; Matos & Gaspar, 2003; Matos et al., 2003; Matos, Gaspar, & Gonçalves, 2004; Matos, Gonçalves, & Gaspar, 2005).

Survey data from the present study indicated that African adolescents tended to begin sexual life early, use condoms infrequently, and have more difficulties in talking with parents about sex. Multivariate models confirmed that boys, older adolescents, and African migrant adolescents were significantly more likely to have initiated sexual relationships, regardless of quality of communication about HIV prevention either with parents or peers. In the group that had initiated sexual intercourse, there

were no significant differences according to gender or age. However, African migrant adolescents were significantly less likely to use a condom at last intercourse. Uncomfortable communication with family about HIV prevention was not a significant predictor, whereas an uncomfortable peer communication about HIV prevention was associated with not using condoms. These findings are consistent with previous research (Gaspar, 2005) and provide additional information about the unique sexual risk behavior of African migrant adolescents.

Focus group findings provided additional information about the cultural-specific educational needs of African migrant adolescents. Boys and girls agreed that it is up to the male to decide about condom use, and girls viewed even unprotected sex better than not being cared for. Some girls indicated that getting pregnant young was normative. Adolescents also reported being uneasy talking to parents about sex. Both parents and adolescents expressed inhibition and lack of interest in talking to each other about sex and related issues. Parents did not feel well-informed and reported a lack of comfort talking about these issues with their children. Adolescents felt uneasy talking with their parents about sex and felt that parents were poorly informed about sex-related issues. Sexuality and HIV were considered taboo themes for these parents and adolescents. These results reflect an urgent need to promote communication skills for both parents and adolescents to better enable them to discuss emotions, relationships, sexuality, contraception, and AIDS. The participants in the focus groups (adolescents, parents, and professionals) felt that school could be a good location for this intervention. However, some African migrant adolescents preferred the Internet and leaflet sources for information about sex. Parents felt that sex education should be structured and teachers needed special training on these topics.

Focus groups findings illustrated the cultural and gender aspects that characterize the sexuality of this adolescent group. For example, girls reported more social pressure and social prejudice regarding female sexual behavior and condom use. Pregnancy during adolescence was one of the themes that some participants considered an important issue. However, teen focus group participants' indicated that the lack of information about contraceptives is less of a problem, and that some female adolescents wish to become a mother for emotional and social reasons. Given that adolescents often experience emotional and interpersonal difficulties, in addition to lacking experience with and of formal sources of information about sexuality, successful interventions should also promote emotional and relational skills.

Both migrant status and low SES are often associated with poor communication with family, poor access to reliable information, and higher sexual risk taking. Almost half of the migrant adolescents in this study speak another language or dialect at home and have problems expressing themselves in Portuguese, and these adolescents may experience low social support and difficulties talking to parents about sexuality, safer sex, and STIs.

The limitations of the study include the cross-sectional design and self-reported findings. However, the sample is rather large and the use of both quantitative and qualitative methodologies provided evidence of consistent findings. Overall, the findings support the need for intervention to recognize cultural distinctions that characterize this poor migrant community (Elifson et al., 2006; Gaspar, 2005; Tortolero, Markham, Parcel, et al., 2005).

Recommendations for Health Interventions

Portuguese school populations are increasingly multicultural with the arrival of a large number of immigrants from Africa and elsewhere. Many migrants experience poverty, linguistic handicaps, social exclusion, poor education, and health risks, placing them and their adolescent children at elevated risk for sex-related problems. Dancy and Berbaum (2005) suggest that instances of HIV within a community are significantly related to inconsistent condom use. Goals for safer sex interventions should promote skills that would enable adolescents to be assertive, effective communicators, and informed about these topics. Successful intervention would not merely prevent risk behaviors but also promote well-being, positive expectations toward the future, and a sense of belonging and being socially supported (Rice & Farquhar, 2000).

For interventions to be effective, parents and health and education professionals must have adequate skills and training to meet the specific needs of these target populations (Kahssay & Oakley, 1999; Matos, 2005; Muuss & Porton, 1999; Muza & Costa, 2002; STEP/BIT, 2003; Whitaker & Miller, 2000). Programs should promote well-being, social and problem solving skills, school attendance and success, and not merely preventing sexual risk behaviors.

According to Gaspar (2005) and others (Sleeter, 2001), migrant students can easily become disengaged at school and drop out because curriculum, teachers, and school systems as a whole are unable to bridge cultural gaps due to a limited understanding of what multicultural teaching

entails. Further, since risk behaviors are embedded in the psychosocial context, preventive intervention should be implemented at school, family, and community levels (Rice & Farquhar, 2000). Politicians, educators, health professionals, and other professional groups are encouraged to face the challenge of implementing effective interventions based on an understanding of cultural diversity.

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