



Structural Racism and Its Influence On Sexual and Reproductive Health Inequities Among Immigrant Youth

Elizabeth Salerno Valdez^{1,2}  · Jazmine Chan¹ · Andrea Donis¹ · Camille Collins-Lovell¹ · Saharra Dixon¹ · Elizabeth Beatriz² · Aline Gubrium¹

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Abstract

This community-based participatory research study explores the influence of structural racism on sexual and reproductive health (SRH) inequities among immigrant, including refugee, youth. We conducted interviews with emerging youth and youth service providers living in two communities in Massachusetts. Our results detail three major themes illustrating how structural racism influences SRH inequities among immigrant youth: (1) lack of culture-centered SRH supports for recently immigrated youth; (2) immigration enforcement and fear impacting access to adolescent SRH (ASRH) education and services; and (3) perceived ineligibility related to tenuous legal status as a barrier to accessing ASRH services. Conclusions: Findings illustrate the importance of rooting sexuality education curricula in a culture centered framework that recognizes local cultural understandings, acknowledges structural constraints faced by young people, and prioritizes youth agency and voice when engaging in this work. Raising awareness of SRH resources available to immigrant youth may expand access for this underserved population.

Keywords Immigrant youth · Sexual and reproductive health · Structural racism

Background

Despite significant improvements in adolescent sexual and reproductive health (ASRH) in the United States, ASRH inequities among immigrant, including refugee, youth have persisted - and sometimes increased. [1, 2] Growing evidence indicates the powerful role of structural racism on immigrant health. [3] However, research on immigrant ASRH often focuses on individual level risk behaviors and disease outcomes. [4] Immigrant ASRH inequities have largely been explained by cultural and religious factors, lower socioeconomic status, social isolation, lower educational attainment, and immigration and acculturation

discrepancies. [5–7] Scant research has examined the influence of structural racism on immigrant youth SRH.

Theoretical/Conceptual Framework

A structural racism and structural violence framework is necessary to understand and address SRH inequities experienced by immigrant youth because the barriers immigrant youth encounter are systemic in their nature and function. [8, 9] Racism is a system of oppression that operates at the internalized, interpersonal, institutional, and structural levels. [10] Structural racism is defined as the ways in which societies foster racial discrimination, through mutually reinforcing inequitable systemics (in housing, education, employment, earnings) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which taken together affect the risk of adverse health outcomes. [8] Structural violence refers to institutional limitations placed on groups of people that prevent them from receiving the quality of life they otherwise would be able to obtain. [11] Structural violence functions covertly as these limitations are often perceived as natural (political, economic,

✉ Elizabeth Salerno Valdez
esalernovald@umass.edu

¹ Department of Health Promotion and Policy, School of Public Health and Health Sciences, University of Massachusetts Amherst. Arnold House, 715 North Pleasant Street, 01003 Amherst, MA, United States

² Massachusetts Department of Public Health, 250 Washington St, 02108 Boston, MA, United States

religious, cultural, or legal) processes of social life since they are embedded in the social fabric. [11] Altogether, these limitations are defined as *violent* because they cause harm by denying certain people access to the basic needs required to reach their full quality of life. [12]

Racism is an insidious and foundational part of the social-cultural experience in the U.S. and manifests in both blatant and elusive contexts with different levels, forms, and intentionality with varying sites and frequencies. [13] In a review of the literature, Misra and colleagues describe the ways that structural racism affects immigrant health via three key pathways: [1] formal racialization via immigration policy and citizenship status that curtails access to material and health resources and political and civic participation; [2] informal racialization via disproportionate immigration enforcement and criminalization, including ongoing threats of detention and deportation; and [3] intersections with economic exploitation and disinvestment such as labor exploitation and neighborhood disinvestment. [3] Literature from 1986 to 2016 shows that structural racism and immigration-related policies impact the physical and mental health of undocumented immigrants by limiting their access to social institutions and health-related services. [14] While there is emerging literature exploring the role of structural racism on immigrant adolescent health in general, [15] there is little known about structural racism and its role in contributing to SRH inequities among immigrant youth.

The current study aims to address this gap in the literature by providing data directly obtained from immigrant emerging adults and their service providers to understand how structural racism, in combination with other systems of oppression, contributes to inequitable SRH outcomes for youth, including immigrant youth. Our findings contribute to emerging research calling for new models, measures, and interventions that directly address the influence of structural racism and structural violence on the SRH of immigrant youth. [3, 16]

Methods

We present findings from a four-year Community-Based Participatory Research (CBPR) study begun in early 2020 by two researchers from a state university in Massachusetts, and funded by the Massachusetts Department of Public Health (MDPH), Office of Sexual Health and Youth Development in the Bureau of Community Health and Prevention. The study received human subject approval from the university Institutional Review Board.

Participants

CBPR is an established approach to research, suited for working with underserved and historically marginalized groups. [17] Using a CBPR approach, we partnered with two youth serving organizations in the Springfield, MA metro area and Lynn, MA to engage key stakeholders to form community advisory boards (CAB) in each city. Both cities have large im/migrant populations and high indicators for social inequality. [18] The youth-serving organizations in each community referred potential CAB members to the academic researchers for recruitment. Research assistants then contacted each person via email and received informed consent via DocuSign. CAB members either provide services to youth (n=10) or are emerging adults (ages 18–24) (n=7) who have received services from youth-serving organizations in Springfield or Lynn. While there was no eligibility requirement that CAB members identify as im/migrant, all CAB members identify as being from at least one historically marginalized population (e.g., Black or African American, Latinx, im/migrant, LGBTQ+). In this paper, we include consideration of any data related to discussion of im/migration and sexual and reproductive health. Thus, reported data may reflect the perspectives of CAB members who did not identify as im/migrant.

Data Collection

CAB Member Interviews

We completed individual interviews in English with all CAB members via Zoom. The one-hour interviews sought to understand: (1) systemic issues (e.g., racism, hetero/sexism, poverty, housing, food insecurity, policing, education/schooling, COVID) that affect young people in their community and their SRH; (2) personal experiences with these issues; (3) resources for young people in the community and what's missing; (4) experiences with SRH curricula/programming; and (5) whose voices or perspectives are missing when considering SRH inequities. CAB interviews were recorded on Zoom and transcribed and reviewed for accuracy and content by a research assistant. CAB members were each compensated with a \$25 online merchandise card for their participation in an interview.

CAB Meetings

Hour-long CAB meetings occurred quarterly on Zoom and focused on discussing the study process and findings. CAB members were asked to provide their feedback and perspective on the progress of the study. CAB meetings were recorded on Zoom and transcribed and reviewed for

accuracy and content by a research assistant. CAB members were each compensated with a \$25 online merchandise card for their participation in each meeting.

Data Analysis

The two study co-principal investigators and three research assistants independently reviewed and generated themes from transcripts of the interviews and CAB meeting recordings. The research team then conducted a second level of data analysis via weekly team meetings on Zoom. We explored and identified emerging themes within individual cases, and then across the data sources to consider how identified themes played out across the *corpus* of data. Through these data explorations, the research team developed a preliminary list of codes for organizing the data, and then finalized a codebook with detailed description; inclusion and exclusion criteria; and typical, atypical, and close-but-no exemplars for each code to guide data coding. [19] We reviewed the data and tested for intercoder reliability, using the codebook to guide further analysis and interpretation. We used a content analysis approach, in which coding categories are derived directly from the text, to examine key themes emerging in the data. [19] We used directed content analysis based in theory (i.e., structural violence) to examine structural dynamics (i.e., historical, political, economic) surrounding these themes. [19]

CAB Member Check

Following the research team data analysis process, we presented an overview of key themes arising from the data to CAB members during a quarterly meeting via Zoom. The presentation was structured using a Socratic method, in which the academic research team posed a research question (e.g., how do legal status, enforcement and immigration dynamics shape young people's experiences in your community?) on a PowerPoint slide. The research question was related to an emergent theme (e.g., legal status and health service seeking practices) to encourage CAB members to discuss their own perspectives on the theme. The research team then briefly summarized CAB member discussion, and then presented a third slide with empirical materials drawn from CAB member interviews and prior CAB meetings to provide further elicit discussion on the theme. [20] Content from the CAB member check sessions is included in the presentation of results.

Results

The results detail three major themes illustrating how structural racism and structural violence contribute to SRH inequities among immigrant youth: [1] lack of culture-centered SRH supports for recently immigrated youth; [2] immigration enforcement and fear impacting access to adolescent SRH (ASRH) education and services; and [3] perceived ineligibility related to tenuous legal status as a barrier to accessing ASRH services.

Theme 1: Lack of Culture-Centered SRH Supports for Recently Immigrated Youth

Participants reported that translation of English-language curricular materials is one of the few ways that public schools and community organizations may meet the sexuality education needs of recently immigrated youth. However, they noted that this strategy does not account for the local cultural understandings about sexuality or the lived experiences of immigrant youth.

Most services do not even hit the bare minimum of translation. Many SRH providers and teachers/staff tasked with sexuality education in the schools only speak English, despite serving a large immigrant population, especially in Lynn, making it challenging to answer questions, convey accurate SRH information, build rapport, and connect with their students/patients. One youth service provider noted:

Right now, [sexuality education is] only available in English and in our health classes ... it's not inclusive at all of, like, language. So, what we do, [in the middle school] normally is we spend a lot of time translating our material...as best we can. Handouts, anything we're writing up on the board, any other materials cards, you know, games that we're playing. We try to make sure that we get those materials together and have it translated for them. Myself and the other two educators, we don't speak Spanish. So that does cause, you know, it's a language barrier and it's really difficult because if they have questions, it can be really hard to make sure that we're understanding them correctly and giving them the correct information.

Participants noted that when translation was available for students whose primary language was not English, that translations were not thorough. One emerging adult commented:

And they [educators] don't teach it [sexuality education] in both languages. So, it's not like some of the Spanish kids are getting anything if English is, you know, new to them. And I don't know if the ESL

teachers even translate all of that to them... A couple of times we had an ESL class, and the translator wasn't that good, like you know, she wouldn't translate everything.

Participants also highlighted the importance of offering school-based ASRH education and services as school may be the only safe space for immigrant youth, particularly non-English native speakers, to access and feel comfortable speaking about sensitive topics, like Plan B or abortion. One youth service provider noted:

I also feel like kids that are born here are more likely to get services like a Plan B, or you know abortion, whereas kids that are not born ... they're less likely to talk about those issues of Plan B, or, you know, abortion or anything like that, or terminating pregnancy... I think it's misinformation. Because I think a lot of them [not born in the U.S.] don't talk to their parents about their, um, their sexual health. And if it's not provided by the school or they feel like if they have to go to, like, the Community health Center or get any service that their parents have to know about it... And a lot of times kids don't want their parents to know about their sexual health...

Participants also noted that there is a lack of representation of immigrant communities among school and community-based service providers. Most teachers, sexuality education staff, and health care providers identify as mainland U.S. born and white and typically reside outside of the community. Participants perceived that immigrant youth are unable to relate to their teachers and health care providers, or foster relationships with them, due to a lack of local cultural connection. One youth service provider spoke on behalf of their patients who experienced receiving care from providers who are not representative of their immigrant community:

...[M]y providers don't look like me and the places I go... They can't speak my language, they can't... If I have a caregiver that's supportive to come with me, they [youth's health providers] don't speak my caregiver's language. And so how can they even, if I am trying to connect with them on a practical level, how can they possibly understand me if they have not experienced one iota of what I've experienced?

Theme 2: Immigration Enforcement and Fear Impacting Access to ASRH Education and Services

Participants shared that immigrant youth have experienced individual and community trauma around immigration enforcement in their communities. These traumas have implications for immigrant ASRH. Participants reported that immigrant youth and their families fear seeking health services at schools and in health centers due to fears of deportation or revealing their family's legal status. One youth service provider reflected:

They're afraid. Like, I think you know with immigration, especially with ICE and everything that happened these last couple years. I think that has, it scares these kids. Because they've seen their families broken up. And for them letting anybody know anything is a fear, it's a real fear, um, you know? I don't think that people understand it as much. You know, I see it. Like I have seen it at [the high school]. I've seen it at the Health Center when the families, you know, when I'm trying to get resources for them that are free, that don't, you know, that don't involve anything. And they still hesitant about accepting it...

In addition to the fear experienced by local immigrant youth due to ongoing immigration raids in their communities, participants shared the ways that community organizations have tried to assist immigrant families, including by providing resources on legal rights. One youth service provider noted:

There - you know, neighbors possibly calling the police on them. We - in [name of city], there were a lot of ICE raids that were happening in our community. And that was really scary for our girls. I mean, we had to have protocols at [organization] of like, you know, if [ICE] came to the building, like, not letting them in. We were handing out cards to the girls, you know, to bring home, if [ICE] came to your door, these are your rights...

An emerging adult participant expressed fears of outing their parents as undocumented if they discussed their legal status when accessing SRH services and other community-based resources.

I'm gonna be scared about talking about it. But I think if I keep, like, hiding the story, or, like, who I am or because nobody knew I was undocumented. They just thought I was another, you know, kid who was born here. No, that wasn't the case. But I was just more,

more worried about my parents than myself. Because I feel like I have a backup, right? I had, like, all these, like...mentors. And maybe, you know, I felt like I was protected. But everyone else that was in the house, they wasn't protected, I felt.

Theme 3: Perceived Ineligibility Related to Tenuous Legal Status as a Barrier to Accessing ASRH Services

In a related theme, participants reported that many immigrant youth and families perceive that they have limited health care options due to their legal status, despite existing free healthcare options available for immigrant and undocumented families in the state of Massachusetts. One service provider commented on the lack of awareness of immigrant youth and families regarding services available to them through schools, including vaccines (e.g., HPV, COVID-19), due to questions about their healthcare eligibility and immigration status.

...kids that are from families that are immigrants that are, you know, they might have limited health care and may not know that it's free and it's an option... Some of those kids are afraid to even accept. Like even though they're called into the nurses, they go into the nurse's office, the nurses, telling them, "You need these vaccines, or you can't stay in school." Because, you know, that's part of their rules. "But you can go right in the next door and get your vaccine?"

Another emerging adult noted that the resources that do exist are not well-known or easy to access for immigrant youth and families:

At the beginning, I didn't have any healthcare, like, because I was undocumented... My mom was able to apply for something, but it didn't cover a lot of the things that maybe I needed... Or maybe they're working, and they're not working anymore, so they don't have any coverage... I've seen that a lot too... But, um, regarding that...they know the [SRH] resources that they have available? I don't feel like, um, there's something that is out there or for people to see easy to access to.

An emerging adult who also works as a youth service provider commented that a lack of promotion of available services by youth-serving organizations plays a role in the perceived lack of available SRH resources in and for immigrant communities.

So, I know Thursdays at the Community Health Center...they have like a teen night or, like, a teen drop-in hour where you can come, you can ask questions, you can get contraceptives, you can get tested, all types of things like that. And I didn't know about this until I went to [organization] because they have a partnership with Lynn Community Health Center. And I would try to tell people as much as I could at [school]. But I think, I know people don't know about it, because people aren't talking about it, and we're not taking advantage of, ... Just, there's no like, like, promotion about these...resources.

Discussion

Findings from this CBPR study with emerging adults and youth service providers illustrate the ways that structural racism influences SRH among immigrant youth. CAB members' perceptions confirm what is becoming generally accepted in the field: that structural racism exacerbates inequitable adolescent health outcomes, and that future research should focus on identifying effective interventions to address or mitigate its effects. [3] Even so, it is critical that public health researchers and practitioners understand the community-specific and nuanced experiences of exposure to structural racism in order to design effective responses. The current study was designed with that goal in mind and is part of a larger project to re-envision local and state level responses to ASRH inequities, particularly among those faced by immigrant youth.

Health literacy is a central focus of Healthy People 2030 because literacy and health are interconnected. [21] Having limited English proficiency in the U.S. can be a barrier to accessing healthcare services, understanding health information, and subsequently using health information rather than simply understanding it. [22] CAB members reported that translation of English-language curricular materials and use of translators is the primary strategy for providing sexuality education and SRH care for English language learners. English-language translation of SRH curricula and resources is historically a quick fix for making programs more inclusive for immigrant youth community members. This solution is superficial and does not center the deeper histories and current lived experiences, the local cultural dynamics, or the creativity and voice of the communities served. [23] As Baugh argues, "If we ever hope to overcome linguistic ignorance and uninformed assumptions about race and language, then educators must participate in systemic reforms that will ensure educational equity". [24]

Indeed, historically when we think about the term inclusivity in the context of sexuality education, it generally references materials and approaches focused on LGBTQ+identified folk. [16, 25] While important, this framework may leave out other historically marginalized communities, including racial and ethnic minoritized populations, persons with disabilities, and immigrant populations. [23, 26] Even still, inclusive sexuality education for LGBTQ+ youth is sub-optimal and often does not reflect the intersectional identities of youth. [25] Most U.S.-based sexuality education has been designed by and for cis-gender, mainland U.S.-born white people without disability, and has historically failed to reach and impact historically marginalized students and communities. It is important for historically marginalized populations, such as immigrant youth, to see their intersectional identities reflected in their materials and modes of learning, which serves as an important incentive to address the ways that current U.S.-based sexuality education fails to influence immigrant youth.

Related studies reveal few inclusive sexuality education curricula that account for the socio-cultural and everyday concerns of immigrant youth. [23, 27, 28] Developing culture-centered sexuality education programs for immigrant youth that take into account local cultural understandings and values, structural constraints (i.e., historical, economic, political, and other local structural dynamics), and that position youth with agency and voice when engaging in the sexuality education context is crucially needed. [29] Promising strategies to be used in both program development and program implementation include didactic and participatory methods, such as youth participatory action research (YPAR), CBPR, and arts-based methods like digital storytelling, body mapping and story circles, and poetic inquiry. [27, 30–33] These strategies are successful at engaging immigrant youth by increasing their sense of autonomy and self-expression, and by valuing and amplifying their voices in forms that do not rely solely on spoken or written English-language skills.

Our results confirm previous studies, showing that efforts to hire SRH educators and service providers from local communities with diverse linguistic and socio-cultural backgrounds and skillsets, as well as training based in the tenets of cultural humility should be prioritized. [34, 35] Further, our findings reflect the importance of schools as safe spaces for immigrant youth, where they can receive services and resources, ideally with confidential spaces that feel safer for privacy purposes. Similarly, our results underscore the important role to be played by youth-serving organizations, as they can facilitate network-based social capital and positively affect access to SRH education and resources. [33]

Finally, our findings confirm previous research positing that immigration status in the U.S. is a form of structural

violence because it attacks immigrant youths' ability to reach optimum SRH. [36, 37] Our findings show that immigration enforcement, and tenuous legal status and fear of deportation, particularly for mixed-status families, limits access to health resources, with serious implications for SRH among immigrant youth. This fear, coupled with lack of awareness of healthcare services, available medical insurance, and the burden of costs related to seeking such services, pose as significant barriers to access for immigrant youth, despite expanded insurance coverage in Massachusetts. [38] Relatedly, other studies report that being discriminated against for speaking a language other than English has made immigrants hesitant to continue accessing healthcare services. [34] Future policy and practice efforts should emphasize expanding awareness of available healthcare coverage and culturally appropriate services to immigrant communities. More pressing is the need for immigration reform to legalize millions of undocumented and mixed-status immigrants, who contribute tremendously in both formal (tax dollars, labor) and informal (culture, diversity) ways to the U.S.

New Contribution to the Literature

Perspectives from emerging adults and youth service providers provide novel insights into the understudied area of the sexual and reproductive health of immigrant youth. Our results illuminate the lack of SRH supports for non-English native speaking immigrant youth. Particularly important is the finding that while certainly well-meaning, inclusivity predicated on mere language translation is an albeit rare, but also failing strategy for meeting immigrant youth where they are at. Finally, while it is well-studied that immigration enforcement and tenuous legal status have implications for immigrant health, our study is one of few that reveals its influence on immigrant ASRH, including limiting access to important SRH services and resources at school and in the community.

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