Youth of Color
At Disproportionate Risk of Negative Sexual Health Outcomes

THE FACTS

In the United States, rates of HIV and other sexually transmitted infections (STIs) as well as of unintended pregnancy are disproportionately high among youth of color, especially among African American/black and Latino/Hispanic youth. Social, economic, and cultural barriers limit the ability of many youth of color to receive accurate and adequate information on preventing HIV, STIs, and unintended pregnancy. It is important to promote programs that seek to make structural and social changes and lessen risky sexual behaviors by encouraging condom use, delay in sexual initiation, partner reduction, and early HIV/STI testing and treatment. Research and resources must be directed toward addressing the underlying social forces that contribute to these disparities.

YOUTH OF COLOR SUFFER RELATIVELY HIGH RATES OF HIV AND STIS

- In 2007, African Americans/blacks and Latinos/Hispanics accounted for 87 percent of all new HIV infections among 13- to 19-year-olds and 79 percent of HIV infections among 20- to 24-year-olds in the United States even though, together, they represent only about 32 percent of people these ages. Asian and Pacific Islanders (APIs) and American Indians and Alaska Natives account for about one percent of new HIV infections among young people ages 13-24.[1]
- Young men of color who have sex with men are particularly at risk. Men who have sex with men accounted for sixty-five percent of all HIV diagnoses in 2004. And between 2001 and 2006, the number of HIV cases among men who have sex with men rose for all races, but there was a particularly sharp increase for young black men who have sex with men - 93 percent.[2]
- In 2008, the chlamydia rate among African American/black women ages 15 to 19 was nearly seven times higher than among white females (10,513.4 and 1,534.5 per 100,000 females, respectively). Among African American/black males ages 20 to 24, the chlamydia rate was eight times higher compared to white males (3,825.4 and 465.9 per 100,000 males, respectively).[3]
- In the same year, 71 percent of all reported cases of gonorrhea occurred among African American/blacks, for whom the gonorrhea rate was 625 per 100,000 population compared to 110.2 among American Indians/Alaskan Natives, 66.8 among Latinos/Hispanics, and 31 among whites.[3]

BIRTH RATES FELL AMONG TEENS IN ALL ETHNIC/RACIAL GROUPS, BUT IN SOME GROUPS, REMAINED HIGHER THAN THE OVERALL RATE

- Preliminary data for 2008 found a two percent decrease to 41.5 per 1,000 births among women ages 15 to 19, reversing a brief two-year increase that had halted the long-term decline from 1991 to 2005.[4]
- Between 2007 and 2008, birth rates among 15- to 19-year-old women declined in all ethnic/racial groups with statistically significant declines ranging from two percent (non-Hispanic white and non-Hispanic black teens) to five and six percent for Hispanic and Asian and Pacific Islander teens. The rate for Hispanic teens fell to 77.4 births per 1,000, the lowest rate ever reported for this group. Although rates for Hispanic and non-Hispanic black teens remain higher than rates for other groups.[4]
- In 2008, according to preliminary data, Hispanic teens had higher birth rates than any other group—77.4 per 1,000 women ages 15 to 19 compared to 62.9 among non-Hispanic black teens; 58.5 among Native Americans; 26.7 among white, non-Hispanics; and 16.2 among Asian and Pacific Islander teens.[4]

SEXUAL RISK BEHAVIORS AMONG YOUTH OF COLOR PUT THEM AT RISK

- Among high school students in 2009, 24.0 percent of Asian, 42.0 percent of white, 47.9 percent of Native Hawaiian or other Pacific Islander, 49.1 percent of Latino/Hispanic, 59.4 percent of American Indian/Alaskan Native, and 65.2 percent of black students reported that they had ever had sexual intercourse.[5]
- At the same time, the percentage of high school students reporting that they had sexual intercourse with four or more people during their life was highest among black students (28.6 percent) and American Indian/Alaskan Native students (23.4 percent). Eighteen percent (18.4

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Social, economic, and cultural barriers negatively impact young people's ability to avoid HIV, STIs, and unintended pregnancy.

percent) of Native Hawaiian or other Pacific Islander, 14.2 percent of Latino/Hispanic students, 10.5 percent of white students, and 5.2 percent of Asian students reported having four or more partners.

- Among sexually experienced high school students in 2009, 61.1 percent reported using a condom at most recent sex. Male students were significantly more likely to report condom use than female students (68.6 percent versus 53.9 percent, respectively). The prevalence of having used a condom was during most recent sex was higher among white students (63.3 percent) and black students (62.4 percent) than Latino/Hispanic students (54.9 percent).
- In one study, from 1993 to 2005, condom use at last sexual intercourse was consistently lower among API high school students (48.9 percent) than their Hispanic (55.2 percent), white (58.6 percent), and black (65.7 percent) peers.[6]

YOUTH OF COLOR FACE SIGNIFICANT BARRIERS TO HIV/STI AND PREGNANCY PREVENTION SERVICES

- Sexual concurrency (partnerships that overlap in time) may be an important route of HIV and STI transmission among youth of color. In one study, approximately one-fifth of sexually experienced Latino youth reported having concurrent partnerships.[7]
- In a study of Latino youth ages 16 to 22, men were more likely than women to report sexual concurrency with at least one other person, consistent condom use with their main partner, and a desire to avoid pregnancy. Women were more likely than men to report longer sexual relationships with their main partner, more acts of sexual intercourse with main partner without a condom, and greater overall trust in their main partner. Participants who perceived infidelity with their main partner, but not one's own sexual concurrency, were more likely to engage in condom use and fewer acts of sexual intercourse without condoms.[8]
- In a study of African American sexually experienced heterosexual couples ages 14 to 19, males were significantly more likely to report concurrency compared with females, 38.4 percent and 13.3 percent, respectively. Among couples in this study, agreement between perceptions of sex-partner concurrency and partner-reported behavior was low. Individuals who presume they are in a mutually monogamous relationship may underestimate their own STI risk.[9]
- Young African American women at high-risk of HIV/STI infection may experience male-dominated power imbalances and also fear negotiating condom use with their male partners.[10,11]
- One study found that many African Americans and Latinos held misperceptions about HIV transmission, trusted the accuracy of partners' reported histories, and, particularly among women, misunderstood the meaning of safer sex.[12]
- Social norms discourage openly discussing sex. For example, in one study, less than half of sexually active API students reported conversations with their parents about HIV-related issues. In addition, high HIV-related stigma was reported.[6]
- Persistent inequality and painful memories of medical abuses and the consequent mistrust of the U.S. government contribute to conspiracy theories, such as HIV as an agent of genocide, that hamper HIV education efforts in some racial/ethnic communities.[13]
- Urban minority adolescents reported high levels of worry about AIDS, but they reported equal or greater concerns about having enough money to live on, general health, doing well in school, getting pregnant, and getting hurt in a street fight.[14] For these women, HIV risk reduction could be secondary to basic needs, such as housing, food, transportation, and child care.[15]
- Youth of color experience higher rates of medical indigence than do white youth, and they more often confront financial, cultural, and institutional barriers in obtaining health care.[16] For many youth of color, publicly funded health insurance provides limited access to comprehensive, adolescent-appropriate health services.[16]

PROGRAMS CAN BE EFFECTIVE IN SERVING YOUTH OF COLOR

- **Promote reproductive justice.** *Reproductive justice* is defined as the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights.[17]
- **Promote gender-specific interventions.** Young people may seek out HIV/STI and teen pregnancy prevention interventions to meet gender-specific needs, and these differences should be taken into account when designing interventions. [18]
- **Support structural interventions** which seek to address or influence social, political and/or economic environments to redress dispari-

ties in HIV, STI and teen pregnancy. Examples include, but are not limited to:

- condom availability programs and comprehensive sex education in schools
- population education – educational techniques designed to raise the consciousness of its participants and allow them to become more aware of how an individual's personal experiences are connected to larger societal problems
- reduction – needle exchange legislation and programs for injection drug users.
- microfinancing – programs that seek to reduce women's vulnerability to HIV/STI by bolstering their economic prospects. One study, a pilot project in Baltimore, MD examined the efficacy of economic empowerment and HIV prevention among women who used drugs and were involved in prostitution. This study demonstrated significant reductions in receiving drugs or money for sex, the median number of sex trade partners per month, daily drug use and the amount of money spent on drugs each day.[19]
- community mobilization
- ensuring access to quality education and health care.

- **Utilize peer influence within social networks.** Research on social networks has found that they include certain peer leaders – members who can influence the behavior of others in the network. Programs can use this influence to affect behaviors that reduce HIV/STI transmission and unintended pregnancy rates, including:
  - *HIV/STI testing*. Programs in which community members recruit friends and acquaintances to be tested for HIV/STI have been found to increase HIV/STI testing rates and even reduce risk behaviors.[20,21] Earlier diagnosis of and treatment for HIV and STIs is essential to reducing viral levels and preventing infertility, respectively.
  - *Condom use*. Studies have shown that adolescents who believe their peers are using condoms are also more than twice as likely to use condoms compared to teens who do not believe their peers use condoms.[22,23] Conversely, one recent study specifically of young African American men who have sex with men found that men at high risk for HIV were less likely to say their friends approved of condom use. Research has shown that African American youth of both sexes were more likely to use condoms at last intercourse than youth of any other race/ethnicity.[5] Programs can build on young African Americans' proven self-efficacy for condom use by teaching all young people about condoms, normalizing condom use as an effective means of preventing HIV and other STIs, encouraging youth to communicate openly about condoms with peers and partners, and making sure condoms and information about condoms are available.

- Promote partner reduction, monogamy, and partner communication. Because concurrent partnerships can greatly increase the "pool" of sexually transmitted infections in one's social network, it is important for programs to teach youth about the risks associated with having multiple partners, teach the benefits of abstinence and monogamy, and to stress the importance of condom use at every act of intercourse. Program planners should also develop interventions to increase partner communication skills among youth.[24]

- Tailor programs to communities served. Researchers have identified cultural competency as an important element in creating programs for racial/ethnic and sexual minority youth. Program planners should identify one of the evaluated sexual health programs which takes into account the cultural, community, and social norms of youth of color and which provide them relevant information in a culturally appropriate manner.[25,26] In addition, program planners may need to tailor programs based on acculturation and other immigration-related factors to reach diverse racial/ethnic youth populations.[27,28]

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Young people need culturally appropriate, evidence-based programs which address behavioral, cultural, and institutional barriers to sexual health information and services.

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