HIV and Young Women and Girls in the United States

Understanding the systemic barriers young women and girls face

One quarter of new HIV cases in the United States are among adolescents and young people between the ages of 13-24.[1] One in five new cases among this age group occurs in young women.[2] Significant racial disparities exist among girls who are diagnosed with HIV during their adolescence and young adulthood, with 85 percent of new cases in this age group occurring among young Black and Latina women and a striking 71 percent among black young women.[3] Many girls and young women face systemic barriers that place them at greater risk of HIV. The following issue brief highlights inadequate sex education, disparate sexual health outcomes, violence, gender inequity and stigma as key areas that policymakers and advocates alike must address if we hope to end AIDS among young women and girls in the United States.

HIV RISK IS INTERTWINED WITH OTHER SEXUAL HEALTH CHALLENGES

Young people ages 15-24 account for half of new sexually transmitted infection (STI) cases in the U.S. each year, with those who experience STIs also more likely to acquire HIV.[12] Despite young people bearing a disproportionate burden of STI and HIV cases in the country, fewer than one in four sexually active youth have been tested for HIV. For many young people, poor sex education, lack of access to health services and concerns about confidentiality can discourage them from getting tested.[13] Many high school-age youth believe that they are not at risk of acquiring HIV in their lifetimes,[14] highlighting a greater need for resources to improve understanding of HIV risk and access to testing.

Sexually active girls and young women may be at risk of unintended pregnancy, in addition to and in combination with HIV and other STIs. Eighty-six percent of new HIV cases among young women ages 13 to 24 result from heterosexual sex, which can also lead to pregnancy.[15] Girls and young women living with HIV who become pregnant are at greater risk of pregnancy complications, including premature birth and miscarriage.[16]

INADEQUATE SEX EDUCATION HEIGHTENS HIV RISK

Education is a key tool for HIV prevention. Sex and health education in the United States is primarily controlled at the local level, with each school district determining content and curriculum for its own students under broad state guidelines, and even broader federal ones. The federal government provides guidance for sexual health education through funding to programs and initiatives that address sexual health needs of adolescents in schools. Ninety-one percent of school-age children attend publicly funded schools, meaning school-based programs and interventions have potential to reach the greatest number of young people.[4] However, as of 2016 only 23 states and DC require public schools to provide sex education, 22 of which mandate both sex education and HIV education.[5] An additional 11 states require HIV education, but no other sex education. Only seven states require that if offered, sex or HIV education must be medically-accurate, age-appropriate, and culturally-appropriate or unbiased.[6] Various studies[7] among youth in the U.S. have found critical gaps in knowledge of sexual health matters including uncertainty about how condoms work[8] and not knowing that HIV is a sexually transmitted infection.[9] Studies show that providing adolescents with sexual health information is an important means of promoting healthy sexual development and reducing negative outcomes of sexual behaviors.[10]

The type of information included in sex education can greatly impact its effectiveness. In states that provide sex education, the definitions of "medically accurate" and "age appropriate" vary.[11] Sexual health education should provide young women and girls with the information and skills to make healthy choices, placing them at lower risk for unintended pregnancy, sexually transmitted infections and HIV. Sexual health education programs must not include scientifically inaccurate information, shame, or disempower young women. It is also crucial to provide information beyond the medical basics or mechanics of sex, such as discussions of healthy relationships, sexual orientation and gender identity, and sexual health services to keep sexual health education relevant to the real lived experiences of young women and girls.

GENDER INEQUITY & STIGMA DRIVE THE EPIDEMIC

Gender discrimination plays an important role in women's relationships and access to resources like healthcare. Many issues converge to place young women at social and economic disadvantage.

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- Women earn less money than men; women of color earn even lower comparative rates.[26] In the U.S., nearly one in eight women remains uninsured even after implementation of the Affordable Care Act, which means cost concerns severely restrict access to regular care and preventive services.[27] CDC reporting from 2013 shows that young black women and Latinas ages 18-24 who were diagnosed with HIV were more likely than their white counterparts to be living without health insurance, unemployed, or living below the Federal poverty level.[28]
- Stigma around sexuality for young women and girls can increase their risk of acquiring HIV, or the negative impacts of HIV diagnosis on their lives. A sexual double standard in the U.S. is well documented:[29] women and girls are harshly judged if perceived as being "too sexual," while men are praised for sexual activity.[30] Stereotypes around sexuality extend to all areas of women's lives, and when a woman engages in casual sex she is more likely to be viewed as unintelligent, socially inappropriate, and desperate.[31] When a young woman believes that she should not be having sex or will be judged harshly for it, she is less likely to feel that she has agency in her sexual decision making, which can lead to riskier sexual behaviors. One study found that nearly one in five young women between ages 14 and 26 believed they *never* have the right to assert their own decisions about birth control or to ask for different sexual activity from their partner, including refusing sex without birth control or asking their partner to stop if they are being too rough.[32]
- Young women may feel unable to initiate these conversations or assert their own needs in a relationship. Difficulty in negotiating condom and birth control use can increase risk of HIV, as well as STI transmission and unintended pregnancy. The 2013 Youth Risk Behavior Survey (YRBS) reported that of sexually active youth in the United States, nearly 14 percent did not use any method to prevent pregnancy during last sexual intercourse; this number was higher for black female (21.2 percent) and Hispanic female (23.7 percent) than white female (11.9 percent) students.[33] Access to pre-exposure prophylaxis (PrEP), a self-controlled and private means of preventing HIV transmission, can be crucial for young women, much in the way that oral contraceptives can be used to prevent pregnancy in some relationships.[34] Women and girls that feel more empowered to make their own choices have more control over their sexual health.[35]

Despite some young women and girls perceived inability to assert control in sexual experiences, they are more likely to bear the responsibility of maintaining sexual and reproductive health in a relationship. Women are often expected to carry the burden of pregnancy prevention in a relationship, as well as HIV and STI testing. Adolescent girls are 10 percent more likely to get tested for HIV than their male counterparts (27 percent vs 17 percent); black adolescent girls are the most likely to get tested, at 36 percent.[36] Because of their increased testing rates, women are more likely to find out their HIV status first, and then may be blamed for bringing HIV into families. This burden can incite fear and hinder women's testing rates. Women living with HIV who face harsh stigma and discrimination often are reluctant to disclose their status due to fear of violence.

Stigma associated with HIV and AIDS is a persisting barrier to HIV prevention efforts, and has negative impact on the overall health and well-being of people living with HIV and their access to health and social services.[37] It also negatively affects an individual's self-concept and mental health once they find out their HIV status.[38] Adolescent girls and young women face these intersecting forms of HIV and sexuality stigma, in addition to other negative societal assumptions about gender roles and intelligence,[39] which can have detrimental impacts on their lives and self-perception.

THE ROLE OF VIOLENCE AGAINST WOMEN AND GIRLS

Women and girls living with HIV are disproportionately affected by intimate partner violence (IPV), or dating violence. Women living with HIV are twice as likely to face IPV and five times more likely to have post-traumatic stress disorder (PTSD) compared to the general population of American women.[17] Young women generally between the ages of 16 and 24 also experience disproportionately high rates of IPV,[18] though little research exists specifically on young women and girls living with HIV. IPV includes various forms of emotional, psychological, and physical violence, as well as reproductive coercion and control.[19]

Young women and girls who are forced into the sex trade, or sex trafficking, are also at increased risk of HIV. In the U.S., the estimated age of entry into the sex trade is between 12 and 14.[20] While the term trafficking often invokes global movement,[21] U.S. federal law considers any person under age 18 to be subject to sex trafficking.[22] Youth involved in the sex trade report that when a third party controls their work, they are significantly more likely to be subject to strict rules and coercion, control, or force.[23] Participation in the sex trade increases risk of unintended pregnancy, STIs, and HIV, in addition to other physical and psychological health risks, violence, and drug use.[24]

When young women and girls face violence and coercion, whether in a consensual or non-consensual relationship, they are at higher risk of HIV and STIs, and other negative sexual health outcomes. To reduce these disparities, young women and girls must be empowered with information about their own health and well-being, and there must be coordinated national, state, and community-level efforts to respond to and prevent the intersection of HIV and violence.[25]

ECONOMIC AND SOCIAL DISPARITIES AFFECT SEXUAL HEALTH OUTCOMES

Young women of color face structural barriers which can increase their risk of HIV. Such barriers include inconsistent access to medical care, poverty and concerns about meeting basic living expenses, fear of violence, and cultural or religious norms and gender expectations.[40] As with many other sexual health outcomes, racial disparities exist in STI and HIV rates. The rate of chlamydia in 2012 was five times higher for black women between the ages of

15-19 years compared to white women of the same age.[41] Eighty percent of new HIV cases occur among adults and young women of color,[42] and young people of color are at greater risk for HIV even when they engage in fewer risk behaviors than white youth.[43]

Youth of color continue to advocate for prevention programs that address their cultural needs and build their condom use and negotiation skills, as well as the removal of structural barriers such as poverty, lack of education, and racism that lead to disparities in HIV rates.

CONSIDERATIONS AND RECOMMENDATIONS

Young women and girls experience serious and persistent inequality in the face of HIV in the United States. To reduce impacts of HIV on young women and girls and ultimately end AIDS, policy makers, service providers and educators must consider the intersectional barriers that put young women at risk.

Policy changes have been slowly made to address these issues on a national level. In 2012 the White House formed an interagency Federal Working Group to explore the intersections of HIV and violence against women and girls, as well as gender-related health disparities.[44] More recently, the 2015 National HIV/AIDS Strategy and Action Plan have highlighted the intent of federal agencies to direct programs and resources to women and girls living with HIV who face IPV. The Strategy and Plan, which highlight the White House's goals to reduce HIV cases in the next five years, specify research, education, and outreach efforts that agencies like the Office on Women's Health (OWH) and the National Institutes of Health (NIH) will take.[45] These include an emphasis on trauma-informed care, or making sure that HIV care options for women and girls screen for and are adjusted according to the realities of their own experiences with violence. The National Strategy and Action Plan also include a significant emphasis on age-appropriate and accessible sexual health education for all Americans, and focused programs for young people, Latinas, and black women.

These have been important first steps, but there remains significant work to be done. We must acknowledge barriers caused by inadequate sex education, disparate sexual health outcomes, violence, gender inequity and stigma. Any policy or program that addresses HIV and AIDS in the U.S. must take into account these barriers to HIV prevention, education, and care. It is necessary to develop and implement specific considerations to address social and economic inequality for young women and girls, especially young black and Latina women, in the national response to HIV and AIDS.

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