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Issues at a Glance

Young Women of Color and Their Risk for HIV and Other STIs

Socioeconomic, cultural, and gender barriers limit the ability of some young women of color to receive information on sexually transmitted infections (STIs), including HIV, access culturally appropriate health care, and reduce sexual risks. Statistics by ethnicity can be misleading due to relationships between socioeconomic status and ethnicity; yet, illuminating the epidemiology of HIV in different populations may promote prevention efforts in under-served communities. The estimated prevalence of HIV and other STIs is especially high for young women of color[1] many of whom lack health insurance and have little or no access to health care.[2] A lack of well-funded prevention programs specifically addressing young women of color further limits the capacity of some these young women to protect themselves against HIV infection.

Behavioral and Socioeconomic Factors Negatively Affect the Health of Young Women of Color

Poverty and access to care—Young women of color are disproportionately members of the working poor who often lack access to affordable, culturally sensitive, and youth-friendly health services.[2] As a result many YWOC receive little preventive health information, including strategies that reduce their risk for HIV infection.

Heterosexual contact—The largest category for being infected with HIV among women of color is heterosexual contact—having sex with a man who uses injection drugs, is HIV-infected, or whose HIV status is unknown to the young woman.[1] For example, in 2002 among cumulative HIV/AIDS cases, 77 percent of Asian and Pacific Islander women, 74 percent of African American women, 72 percent of Latinas, and 62 percent of Native American women reported heterosexual contact as their risk factor.[1]

Communication — Patterns of communication about sexuality differ by ethnicity, age, socioeconomic status, and level of acculturation. Reticence in discussing sexuality occurs among minority populations as frequently as among the U.S. population as a whole. Some Asian Pacific Islander and Latino cultures prohibit or discourage open discussion of topics like condom use, disease, and sexual behaviors.[3,4] African American adolescent females, on the other hand, report receiving information about and discussing HIV and sexuality at school and with family.[5] Young African American women also report feeling comfortable in assertively asking about partners' past sexual risks, although they are often reluctant to ask about same-sex sexual behavior or substance use—behaviors of male partners that can put the young women most at risk.[6,7]

Cultural discomfort with conversations about sexuality and sexual behaviors poses difficulties for some young women of color as they attempt to negotiate safer sex practices and set limits with a sex partner. Numerous studies indicate that African American women and Latinas are concerned about HIV infection but may not use condoms.[6,7,8] While most young women of color report a strong desire to use condoms, those who have low incomes frequently report fear, discomfort, and intimidation about negotiating condom use with their sexual partner.[6,7,9,10] Some young women fear that young men will be angered or offended by questions about past risk behaviors and by requests that they use condoms.[9,11]

Trust in monogamy—The safety provided by monogamy is limited by each partner's past and current risk behaviors. Trusting a male partner who is not monogamous is a serious risk factor for *any* woman and may put many young Latina and African American women at risk for HIV and other STIs.[3,6,9,12] Since different people define monogamy in different ways, safer sex should probably be urged for *all* sexual relationships.

Furthermore, serial monogamy—a series of short-lived monogamous relationships—is fairly common among adolescent women, nearly 16 percent of whom report four or more lifetime sex partners.[13] Having multiple sexual partners (usually four or more) is frequently identified as a risk factor for HIV infection. Early onset of sexual intercourse is often associated with reports of more lifetime sex partners than are reported by young women who initiate sexual intercourse later.[14] Compared to other teens, a higher percentage of African American and Latina young women also report initiating sexual activity at early ages,[5] putting them at higher risk for HIV infection.

Older male partners—A quarter of sexually active men ages 22 to 26 and 19 percent of males ages 20 to 21 report sexual intercourse with a teenage partner during the last year.[15] A significant proportion of Latina and African American adolescent females also report first sexual intercourse with older male partners.[16] Sexual intercourse with older men can expose young women to a sexual partner who has had sex with multiple partners, varied sexual experiences, and/or a history of injection drug use.[17] Differing age and sexual experience may also create power imbalances that limit the ability of young women, including those of color, to negotiate safer sex. Finally, young women sometimes rely on older sex partners for guidance about protection and may receive misinformation that can negatively affect the young women's sexual health.[17]

Cultural Barriers May Affect the Health of Young Women of Color

Cultural barriers prevent many young women of color from gaining the skills and knowledge they need to lessen their risk for HIV or other STIs. Ethnic groups may face different barriers posed by customs, religion, and history.

Among Native Americans, communication barriers complicate HIV prevention. Some terms—such as HIV and AIDS—do not translate easily or clearly in many Native American languages.[2] Tribes may be difficult to target with HIV prevention information due to geographic dispersal, individual languages, and differing customs. For example, the Navajo believe that talking about a disease may bring it into existence in the community.[18]

Statistics may underestimate the rate of HIV infection among Native Americans. Some HIV infected Native Americans may claim to be of another ethnicity to avoid shaming their communities, and HIV testing officials may misidentify Native Americans as being of some other ethnicity.[19,20] In one study, nearly 90 percent of Native Americans living with AIDS were listed as Asian, Latino, or other ethnic background.[18] Inaccurate reporting may lead to decreased funding for prevention efforts targeting Native Americans [20,21] and may also lead Native Americans to deny or underestimate their HIV risk. Finally, substance use—the number one health problem among Native Americans[19,20,21]—is also associated with sexual risk behaviors.[2,24] Many Native Americans do not realize the connections between HIV infection and substance use.[20]

The African American community did not initially view HIV/AIDS as a threat. Early case reports indicated that high risk groups included white gay men, injection drug users, hemophiliacs, and Haitians. As a result, many African American women have not recognized their own risk.[6,23] Historic revelations of unethical experimentation (such as the Tuskegee syphilis study) and misinformation regarding the susceptibility of African Americans to HIV have also affected this community's views of public health messages and practices. Today, suspicion of government agencies, worry about genocide, and continuing conspiracy theories remain current among many African Americans. These factors may result in an unwillingness to be tested or treated for HIV.[18,23]

Latinas often face a significant barrier to negotiating safer sex—Roman Catholicism, the predominant religion of the Latino population.[3,8] Roman Catholicism does not condone the use of condoms or other contraceptives, even though correct and consistent condom use is the best HIV prevention method for sexually active individuals.[18,22] In this regard, studies indicate that Latinas are the least likely teens to report condom use.[5] Catholicism also idealizes female submissiveness to men in relationships and in sexual activities.[3] Cultural imperatives for females' being submissive directly conflict with prevention strategies that ask women to be assertive, to negotiate safer sex, and to be responsible for their own sexual health.[18]

Language barriers may pose difficulties for Latina adolescents who need to discuss their HIV risks with a health professional. Translated HIV educational materials are often limited in their effectiveness because the more than 100 different Spanish dialects have distinctive definitions and meanings. The complexities of HIV transmission and methods of risk reduction sometimes get lost in the translation.[18] Moreover, Latinos may speak Spanish, Portuguese, or one of many indigenous languages. To further

complicate matters, many migrant farm workers—of whom 71 percent are Latino—are functionally illiterate in their native languages.[24]

Asian and Pacific Islanders (A&PIs) often do not recognize the existence of HIV in their communities, perhaps partly due to stereotyping that has labeled A&PIs as a "model" minority.[4] Low rates of teen births, later onset of sexual intercourse than are reported by other youth, and low reported incidence of HIV infection and AIDS all contribute to fostering a perception of little risk for HIV infection among Asian and Pacific Islander youth.[1,2,25,26] Because they have the lowest rates of HIV testing of any ethnic groups, A&PI communities may actually suffer higher rates of HIV infection than current surveillance data indicates.[4] Additionally, the uncertainty about accurate reporting may mean that these communities are receiving inadequate funding for prevention interventions.

Asian and Pacific Islander cultures pose many barriers for public health prevention programs. The A&PI population includes over 60 ethnic groups, speaking more than 100 languages, each needing targeted interventions.[2,27] Denial of same-sex sexual behavior poses a significant cultural barrier since sex with a bisexual male is the leading exposure category cited by A&PI women with AIDS.[27] Further, 66 percent of AIDS cases among A&PI men were transmitted through same-sex sexual behavior, while injection drug use is responsible for 13 percent of the AIDS cases among this population.[1] While Asian and Pacific Islander adolescents initiate sexual intercourse later than other ethnic groups, their risk behaviors are identical to those of other youth once they become sexually active,[26] and their reported rates of STIs suggest that these youth are, in fact, at risk of HIV.

Some Components Are Critical for Effective HIV Prevention Programming for Young Women of Color

In order to reach young women of color effectively, prevention programs should address the specific needs of each ethnic group. Prevention programs should address young women of color in their native language(s), incorporate the values and beliefs prevalent in their culture(s), and actively involve young women of the community in the programs' design and implementation. Creativity and innovation are vital to preventive health programs targeting young people, including young women of color. Recommendations and suggestions for effective programs—derived from research and successful prevention initiatives—follow.

- **Focus on young women's assets.** Programs should concentrate on developing young women's strengths and fostering a spirit of self-determination and high self-esteem.
- **Address all the needs of young women.** Focus on all issues relevant to young women of color, not just on HIV; and/or other issues the young women identify. This may mean focusing on poverty; cultural barriers to sexual risk-reduction, such as pressure to become a parent at an early age; and academic and/or career aspirations.
- **Address the social and cultural factors that influence risk behavior.** Take into consideration the interpersonal, economic, political, socioeconomic, and cultural factors that may increase or decrease risk behavior in individual young women of color.
- **Develop programs that provide peer support and change peer norms.** Encourage young women of color to support one another in changing risk behaviors. Provide space for young women to discuss the challenges such changes present.
- **Be culturally appropriate.** Young women of color are more likely to identify with campaigns, images, and slogans reflective of their population and culture. Successful interventions include members of the targeted population in their planning, staffing, design, and implementation.
- **Build skills.** Teach skills that will help young women of color to make confident, healthy decisions about their sexual behavior. Such skills may include (but are not limited to) the ability to review risky behaviors, make decisions, negotiate, say no, and understand available options. Young women of color need to understand the importance of being assertive in asking sexual partners about their past and current risk behaviors.
- **Use multiple strategies.** Group discussion sessions, one-on-one assessments, media messages, role-playing, self-reflection, and small group work provide opportunities to reach each individual with prevention messages.

*For the purpose of this report "young women of color" refers to heterosexual African-American, Latina, NativeAmerican, and/or Asian and Pacific Islander women between the ages of 13 and 25.

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