

Young African American* Women and HIV

The HIV and AIDS epidemic has disproportionately affected the African American community across time, although rates of HIV infection and AIDS were relatively rare among black women in the early years of the epidemic.¹ Now however, HIV and AIDS disproportionately affect black women, especially young black women.¹ This document looks at some of the factors—behavioral and non-behavioral—that put young black women at disproportionate risk of HIV and recommends policies and programs to assist young black women to protect their health and save their lives.

Biological Factors Affect Young Women’s Risk for HIV Infection

Women’s reproductive biology puts them at greater risk of HIV compared to men. For purely biological reasons, a woman is about twice as likely as a man to contract HIV infection during unprotected vaginal intercourse with an infected partner.¹ Moreover, a *young* woman is even more vulnerable to infection, due to her less mature reproductive tract.²

The same biological factors heighten women’s susceptibility to sexually transmitted infections (STIs) other than HIV, including those that cause genital lesions,³ and teenage women have much higher rates of some STIs than do teenage males. For example in 2004, the gonorrhea rate among 15- to 19-year-old females was 700 cases per 100,000 compared to 321 cases per 100,000 teenage males.⁴ Moreover, women’s reproductive biology also means that STIs are more likely to remain undiagnosed in women than in men. Delayed diagnosis and treatment increase young women’s risk of HIV by three to five times over the risk associated with prompt diagnosis and treatment.^{2,3}

Young black women are at highest risk of STIs, compared to other young women. In 2004 for example, the gonorrhea rate among black women ages 15 through 19 was 14 times greater than among white females the same age (2,791 cases per 100,000 black female teens versus 202 per 100,000 white female teens). Among women ages 20 through 24, the gonorrhea rate was 12 times greater among black women than among white women (2,565 and 209 per 100,000, respectively). The rates of primary and secondary syphilis were 16 times higher among black females ages 15 through 19 than among their white peers (6.5 and 0.4 cases per 100,000, respectively). Among women ages 20 through 24, the rate was 15 times higher among black than white women (13.4 and 0.9 per 100,000, respectively).⁴

Young African American Women Suffer a Disproportionate Impact of HIV and AIDS

- From 2000 through 2003, HIV and AIDS rates for African American females were 19 times the rates for white females.³ Moreover, black women accounted for 67 percent of all new AIDS cases among women in 2003 while white females accounted for 15 percent.¹ Yet, black women constituted 13 percent of the U.S. female population and whites constituted at least 66 percent.⁵

*Sometimes, this paper uses the term African American and sometimes black to refer to all who self-identify as black or African American, including those of Caribbean origin.

- In 2003, black teens (ages 13 through 19) comprised 66 percent of AIDS cases in this age group, although they represented only 15 percent of the teenage population. White teens comprised 11 percent of AIDS cases and accounted for 63 percent of the teenage population.⁶
- According to the Centers for Disease Control (CDC), black youth comprised the largest single group of young people affected by HIV. As of 2001, they accounted for 56 percent of all HIV infections ever reported among those aged 13 through 24.⁷

Behaviors May Put Young Black Women at Excess Risk for HIV Infection

Young black women are sometimes at heightened risk of HIV compared to their white, Latina, Native American, and Asian peers due to different proportions engaging in sexual risk behaviors. In other areas—such as having a partner who injects drugs—young black women are at about the same risk as other women their age.

- **Sexual Intercourse**—This is the primary transmission mode of HIV infection among all American females as well as among black women.⁸ In 2003, 61 percent of all black high school females reported ever having had sexual intercourse, compared to 46 percent of Latina and 43 percent of white female high school students.⁹ Yet, these relative proportions change as young women mature. By age 19, 77 percent of all American females have had vaginal sex; the proportion climbs to 92 percent by age 24. Among black females, 76 percent have had vaginal sex by age 19, 89 percent by age 24.¹⁰
- **Multiple Partners**—Research associates a higher number of lifetime sexual partners with increased risk of HIV infection.¹¹ Among sexually experienced female teens in 2003, 16 percent of blacks reported four or more lifetime sex partners as compared to 11 percent of Latinas, and ten percent of whites.⁹
- **An Older Male Partner**—Young women may be at higher risk of HIV when an older male is their sex partner.⁷ Compared to adolescent males, older male partners may present a greater risk for HIV infection because they are more likely than adolescent males to: have had multiple partners and varied sexual and drug use experience; have concurrent sexual partners; and/or already be infected with chlamydia or other STIs.¹² In addition, power inequity and age differences play a role in the relationship dynamics between an adolescent female and her older male partner. Research shows that, compared to older women, a younger female—trusting the experience and caring of the older male—may be less able to negotiate condom use, may rely more on her partner for sexual health information, and/or may allow her partner to make sexual health decisions that are not in her own best interests.¹³

According to one study of black and Latina women ages 14 through 17, first sexual intercourse for 24 percent of blacks and 55 percent of Latinas occurred with an older male. Compared to their black and Latina peers whose first sex occurred with a male of their own age, these young women were on average significantly younger at first sex and significantly less likely to use a condom during first sex or most recent sex or to have used condoms consistently since becoming sexually active.^{1,13}

- **Male Partner Who Takes Sexual Risks and/or Uses Drugs**—Young women are also at increased risk if a male partner injects drugs or has sex with other men.³ A young woman may be unaware that her male partner is engaging in these risk behaviors.³ Moreover, recent research has highlighted the significant risk for HIV infection that ‘being on the down low’ may pose for men and their female partners—regardless of race/ethnicity.¹⁴ Nevertheless, these risk behaviors do not pose an increased risk for black women relative to women of other race/ethnicity.^{8,14} Cumulatively through 2003, 13 percent of AIDS cases among black women were traced to sexual contact with an injection drug user compared to 16 percent among white women, 19 percent among Latinas, 12 percent among Asian women, and 16 percent among Native American women.⁸ Cumulatively through 2003, three percent of AIDS cases among black women were traced to sexual contact with a bisexual male, compared to four percent of white women, and two percent each among Latinas, Native Americans, and Asian women.⁸

Other Factors May Place Young Black Women at Risk for HIV

Socioeconomic and cultural factors—including poverty, discrimination, and inadequate access to health care, among others—often render young black women more vulnerable to HIV than other racial/ethnic groups.

- **Poverty**—Over 24 percent of blacks lived in poverty in 2003, compared to eight percent of non-Hispanic whites. That means that about one in four African Americans lived in poverty, compared to one in five Hispanics, one in nine Asians, and one in 12 whites.¹⁵ About 22 percent of U.S. *families* living in poverty were black, compared to 10 percent of all families, 21 percent of Latino families, and eight percent of white families.⁵ In 2002, single women were heads of 43 percent of black households, and one study found that children living in households headed by single women were five times more likely to be living in poverty than children living in two-parent households.^{16,17} Limited resources in such households can force women to choose between competing priorities—for example, putting sexual risk reduction second to the need for food, clothing, shelter, safety and childcare.
- **Discrimination**—In the United States, discrimination, as a societal phenomenon, shows up in black Americans' having less access to quality education and health care, fewer opportunities for gainful employment and promotion, disproportionate rates of illness and incarceration, and feelings of sadness and anger. Poverty and disease are the face that discrimination shows to the world.

The effects of discrimination have been widely studied, especially in the South, where 40 percent of people living with AIDS and 46 percent of new AIDS cases occur among black people.¹⁸ Many black women face daily racism, poverty, gender discrimination, and lack of opportunity for meaningful unemployment.¹⁹ But, the South has higher STI rates than any other U. S. region. For example in 2004, the South continued to have the highest chlamydia rates among women; it had the most counties with more than 100 cases of gonorrhea per 100,000 people; and it had the highest case rates of syphilis.⁴

In one study, both HIV-positive and HIV-negative black women living in North Carolina reported HIV risk behaviors. Commonly reported reasons for sexual risk behaviors, regardless of HIV status, were 1) financial dependence on a male partner; 2) feeling invincible to the disease; 3) low self-esteem coupled with a need for love; and 4) alcohol and drug use.²⁰ Through interviews with African Americans living in rural North Carolina, one study found that the difficult economic situation and persistent racial oppression, lack of recreational outlets, boredom, and substance use were co-factors in this state's STI epidemic. Respondents said that few jobs were available locally, and many traveled long distances to work. Those without a car had limited employment options since public transportation was almost non-existent. Most locally available jobs were poorly paid and offered little opportunity for advancement and no benefits. Respondents cited discriminatory actions against blacks in hiring and promotions and worried about their ability to get a mortgage or pay rent. Participants felt that whites received preference in hiring and education. In the end, respondents simply saw sexual risk as a lesser problem in relation to the many others with which they had to grapple.²¹

- **Lack of Access to Health Care**—In 2003, blacks constituted the single largest group of those without health care insurance (nearly 20 percent blacks were uninsured).¹⁵ CDC found that youth who lack access to health care may also lack accurate information about HIV infection, testing, and treatment.⁷

Despite higher rates of HIV testing, blacks responding to government surveys were more likely than whites to say they need *more* information about HIV testing.³ Between 2000 and 2003, 56 percent of those who those diagnosed with AIDS within one year of testing positive for HIV were African Americans. That is to say, blacks were disproportionately likely to be tested late in the course of their illness compared to whites, Hispanics, or others.³ Learning late about one's HIV status has often meant missed opportunities for HIV treatment and HIV prevention.³ Researchers found that African Americans were more likely than others to postpone needed medical care because they: lacked transportation; felt too sick to go to the doctor; or had limited funds for food or housing.³

- **Disproportionate Incarceration**—The United States has one of the highest rates of incarceration in the world.²² Moreover, 63 percent of prisoners are black or Hispanic, although these two groups constitute only 25 percent of the U.S. population.²³ Seventeen percent of people living with HIV and AIDS have spent time in American prisons, and the prevalence of HIV and AIDS is at least six times greater among inmates than in the general population.²² This differential estimate may even be too low since HIV testing is mandatory only upon release from federal prisons.²³ Inmates' susceptibility to HIV infection may result from dangers prevalent in correctional facilities, including shared paraphernalia for injection drug use, tattooing, and body piercing; survival sex; and rape or gang rape.²² Lack of access to condoms means that sex is usually unprotected, also increasing prisoners' risk of HIV.

Across the nation, blacks are nearly seven times more likely than whites to be incarcerated.^{22,23} Women of color comprise 60 percent of female inmates, and black women are about six times more likely to be incarcerated than are white women.²³ Moreover, incarcerated women are three times more likely to be living with AIDS than are incarcerated men, and they report more high risk behaviors, ranging from unprotected sex to sex work and/or substance abuse.^{22,23} Compared to white teens, black youth are three times more likely to be incarcerated in juvenile detention facilities and are five times more likely to be incarcerated before the age of 18.²³

Cycles of imprisonment and release among blacks (male and female) contribute to HIV and AIDS in black communities. Those entering prison are immersed in settings of HIV risk. When they return to their communities, they may transmit HIV to a spouse or partner(s). If they return to prison, their former partners in the community may form new relationships, and share infections with others in the black community.²⁴

- **Survival Sex**—Poverty, violence, and lack of opportunity may force people to have multiple sex partners, sequentially or concurrently. Women living in poverty and/or violent situations may be survivors of forced sex or they may have multiple sex partners in order to cement social networks; acquire food, shelter, or other necessities; and/or seek companionship.

Having multiple sex partners is a primary factor in the sexual transmission of HIV and other STIs. Non-monogamous sexual relationships increase the spread of infection exponentially: one infected person infects another; the two people infect others; these infect as many more, etc. When relationships overlap and one concurrent partner acquires an infection, transmission to all the other concurrent partners can occur in a relatively short period of time. Having concurrent sex partners, even among a very few people, has dramatic consequences for the spread and persistence of infection within a community. As such, concurrent sexual relationships influence both the speed of transmission and the number of people infected.²¹ New data show that multiple partners, sequential or concurrent, are more common among black men than white or Hispanic men. The latest National Survey of Family Growth reported that 34 percent of black males had 15 or more lifetime female sex partners, compared to 18 percent of Latinos and 22 percent of white men.¹⁰ In many of these cases, the woman may have been unaware of the sexual history of their partner.

- **Historical Distrust of Health Care Systems**—Historical oppression, persistent social, economic and medical inequality, and a history of abuse have long strained the relationship between blacks and the federal government.^{3,25,26} Past abuses have resulted in deep-seated mistrust and anger among black Americans—mistrust and anger that persist and that foster conspiracy theories, such as those listed below, that constitute significant barriers to preventing HIV and AIDS among African Americans. Conspiracy theories assert that:
 - There is a cure for AIDS and the government is withholding it from minorities and the poor.
 - AIDS was created in a government laboratory.
 - People who take medications to prevent the onset of AIDS are human guinea pigs for a government that is desperately seeking a cure for an epidemic that has escaped its control.
 - HIV is a man-made virus.
 - AIDS was created by the government to control the black population.
 - HIV and AIDS constitute genocide carried out against blacks.
 - The government promotes the use of condoms in order to limit population growth among blacks.^{3,25,26}

Many black people, at all income and educational levels, hold these beliefs and factor them into their behavioral decisions.^{25,26}

What fuels these theories? The most infamous example is the well-known, government-sponsored Tuskegee syphilis study that ran from 1932 until public disclosure ended it in 1972. In this ‘study,’ black men already infected with syphilis received ineffective treatment from researchers who monitored their painful decline and death rather than providing them with effective antibiotics. In addition, those involved completely ignored resulting syphilis infections in the men’s spouses and cases of congenital syphilis in some of their children.^{27,28}

A more recent example is a government-sponsored study in the late 1980s and early 1990s in which nearly 1,500 minority infants in Los Angeles were vaccinated with an experimental measles drug, known as Edmonston-Zagreb or E-Z. The researchers had *not* disclosed to the children's parents that some of the infants received an experimental vaccine rather than a proven one. Moreover, the experimental vaccine was later found to have serious unintended health consequences.^{29,30}

Examples such as these make many African Americans extremely wary of the government's intentions. Such wariness is understandable, given evidence of past racism and misconduct in medicine and human research. Nevertheless in the face of the HIV and AIDS epidemic, black Americans' wariness truly endangers their health and well-being.

Recommendations

1. **Tackle Racial/Ethnic Discrimination Head-on.** Discrimination—with its resulting distrust, fear, and despair—fuels the epidemic. Consistent, persistent work to end discrimination is critical to stopping the epidemic in its tracks.
2. **Work to End Poverty and Lack of Opportunity in Minority Communities.** Poverty fuels the HIV and AIDS epidemic's disproportionate effect on communities of color, especially black communities. When people have hope for the future and the opportunity to build a satisfying life, they are more likely to be able to make healthy decisions about sex.
3. **Assure Equal Access to High Quality Health Care.** Access to excellent care should not be the prerogative only of the wealthy, but of everyone, especially of children and youth.
4. **Empower Young African American Women** with education and the skills critical to changing the socioeconomic climate of their communities. Young black women need quality education, support in enterprise creation, managerial and professional training, good quality child care, and the assurance that discriminatory barriers are being systematically and determinedly dismantled.
5. **Stress the Importance of Reducing the Number of One's Sexual Partners.** Research, primarily on HIV infection rates in Uganda, has shown that reductions in the number of new sexual partners—both casual sex partners and concurrent partners—has played a significant part in reducing HIV infection rates.¹¹ This risk reduction strategy might work well for communities that fear condom promotion to be a government conspiracy to limit births.
6. **Empower Young African American Women to Lead HIV Prevention and Treatment Programs.** Young women can lead the work that stops the HIV and AIDS epidemic in its tracks. Young black women may need support and encouragement to extend their natural leadership abilities into the public arena and the public health domain. That is, they may need assistance in pursuing careers in medicine, public health, public policy, and research and in building their leadership skills, their self-confidence, and their voice. With such support, they can change the world.
7. **Ensure Young Black Women's Access to Needed Services.** People live within the constraints of their environment—constraints that also influence behavior. Ensure that young black women have access to reproductive and sexual health services—including HIV and STI testing, counseling, and treatment—by assuring that local programs have adequate funding, good locations, and convenient hours.
8. **Target Programs to Young, Black Women.** Include activities that encourage young African American women to deal with issues pertinent to their lives: issues of discrimination with regard both to race/ethnicity and also to gender; discrimination by government, public health, and medical authorities; unequal power status in sexual relationships; substance abuse; and mental and physical health promotion. Interventions should enhance self-esteem and self-efficacy, give hope for the future, and build skills in communication, negotiation, and assertiveness.
9. **Involve the Whole African American Community in Developing, Implementing, and Evaluating Programs.** Involve whole communities in designing and implementing programs. Invite youth—especially young African American women—as well as parents, policy makers, business leaders, schools, churches, and community-based organization to participate actively in selecting, modifying, and adapting effective programs.

10. **Honestly Address Past Abuses in Medical Research.** Acknowledge past abuses and ensure that abuses do not occur in the future. Ensure that black and other minority health professionals share the lead in setting policies, designing research protocols, and implementing programs regarding HIV and AIDS.

Conclusion

Young black women, ages 15 through 24, are at heightened risk of HIV and other STIs. The reasons are complex and include poverty, discrimination, inadequate access to health care, disproportionate rates of incarceration, distrust of the government, and sexual risk-taking that is, itself, largely affected by poverty and lack of opportunity. In order to address the heightened risk for HIV that these young women face, society must directly confront racism and discrimination and it must empower young black women and their communities to lead the struggle to end HIV.

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