This section of the LGBTQ Youth Advocacy Practice Kit provides advocates with information regarding the health needs of LGBTQ youth. While sexual and reproductive health is a critical area of need, advocates have a responsibility to ensure that all of their clients’ health needs are met and this includes ensuring that an LGBTQ youth has access to doctors and medical professionals who make the youth feel comfortable and secure.

LGBTQ youth are particularly susceptible to homelessness and to suicide and also face an increased risk of engaging in alcohol and drug abuse. These realities make it crucial that advocates ensure that LGBTQ youth have access to comprehensive and culturally competent health care resources.
ACCOMMODATIONS FOR HEALTH CARE NEEDS

803.1 When requested by the employee, an employer shall make reasonable accommodations (including medical leave) for transgender-related health care needs that are consistent with such accommodations that are provided for other medical needs. Such needs include but are not limited to medical or counseling appointments, surgery, recovery from surgery, and any other transgender-related procedures.

SOURCE: Final Rulemaking published at 53 DCR 8751, 8753 (October 27, 2006).
The Impact of Homophobia and Racism on GLBTQ Youth of Color

As members of more than one minority group, GLBTQ youth of color face special challenges in a society which often presents heterosexuality as the only acceptable orientation and in which nonwhites have disproportionately higher rates of negative sexual outcomes. Economic and cultural disparities, as well as sexual risk taking and other risk-taking behavior, make these youth vulnerable to HIV, pregnancy, and sexual violence. Holistic, culturally competent health care is essential to their well-being.

Sexual identity formation is not significantly influenced by cultural factors; that is, studies have shown no significant differences between white youth and youth of color in mean age of being “out to self” (16 for young women, 15 for young men); age coming out to others (17 for young women and young men); or age of first homosexual sexual experience (17 for young women, 16 for young men).1,2,3 Black and Latino youth also did not differ from white youth in acceptance of their own sexuality.2 But while GLBTQ youth of color develop similarly to white youth, they must bear the twin burdens of racism and homophobia.

GLBTQ Youth of Color Face Challenges in a Homophobic Society

- After coming out to their family or being discovered, many GLBTQ youth are thrown out of their home, mistreated, or made the focus of their family's dysfunction.4
- Youth of color are significantly less likely to have told their parents they are GLBTQ: one study found that while about 80 percent of GLBTQ whites were out to parents, only 71 percent of Latinos, 61 percent of African Americans, and 51 percent of Asians and Pacific Islanders (APIs) were out to parents.1
- One study found that African American same-sex attracted youth were more likely to have low self esteem and experience suicidal thoughts than their counterparts of other ethnicities. African American same-sex attracted young men were also more likely to be depressed.5
- In a large survey of attendees of Black Pride events, over half reported that their church or religion viewed homosexuality as "wrong and sinful."6
- In many Latino communities, machismo and Catholicism contribute to homophobic attitudes that hamper efforts to reach Latino gay and bisexual youth with HIV prevention information.7
- Asian American and Pacific Islander GLBTQ youth often feel that they have shamed their families when they diverge from cultural expectations to marry and have children.8
- GLBTQ youth of color report feeling pressure to choose between their ethnic and their sexual identities; these youth are less likely to be involved in gay social and cultural activities than their white counterparts.2,3

Racism Coupled with Homophobia Leads to Negative Sexual Outcomes

- Young men of color (ages 15-22) who have sex with men are at disproportionate risk of acquiring HIV: research shows HIV prevalence at 16 percent for blacks and seven percent for Latinos, compared to only three percent for whites.9 Meanwhile, one study of young men who have sex with men found that African Americans engaged in more behaviors that put them at risk for HIV than do white men.10 Latino and multi-ethnic young men also have an elevated risk compared to young white men.9 Researchers have characterized the increasing rates of HIV and sexual risk behavior among young API men who have sex with men as “an epidemic.”11
- In one study, more than half of ethnic minority transgender youth had experienced forced sex, while almost 60 percent had traded sex for money or resources. The researcher characterized ethnic minority transgender youth as “at extreme risk of acquiring HIV.”12

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* GLBTQ stands for gay, lesbian, bisexual, transgender, or questioning.
† Homosexuality/"being gay" refers to persistent emotional and physical attraction towards people of the same gender; bisexuality, towards people of both genders. Same-sex sexual behavior may not reflect either a homosexual or a bisexual identity.
• One study showed that while bisexual and lesbian teenage females were about as likely as heterosexual peers to have had intercourse, they reported twice the rate of pregnancy as heterosexual and questioning young women (12 percent vs. five to six percent respectively).13 Research has also shown that most women who identify as lesbians had sex for the first time as teenagers, and experienced first sexual intercourse with men.14
• Research has found that while black men who identify as homosexual do not have difficulty getting their partners to wear condoms, black men who have sex with men but identify as straight have great difficulty getting their male partners to wear condoms.15

GLBTQ Youth of Color Are At High Risk for Homelessness and Harassment
• A disproportionate number of GLBTQ youth are homeless: one nationwide report found that while only about three to five percent of the population is estimated to be GLBTQ, 42 percent of homeless youth are GLBTQ.16 An estimated 65 percent of homeless people are members of racial minorities.17
• A nationwide study of homophobia in schools found that the majority of GLBTQ youth of color had experienced victimization in school because of either race or sexual identity in the last year, while half reported being victimized because of both race and sexual identity.18 More than a third of GLBTQ youth of color had experienced physical violence because of their orientation.19

GLBTQ Youth of Color Need Culturally Competent Education, Programs, and Health Care
• A recent study of GLBTQ youth who received gay-sensitive HIV prevention education in school showed they engaged in less risky sexual behavior than similar youth who did not receive such instruction.20
• Researchers recommend that HIV prevention messages for Latino and African American gay and bisexual men not only be culturally competent, but also address the larger social, health, and psychological issues which affect them.21, 22
• Researchers who worked with GLBTQ Latina and African American women stressed the importance of affordable, nonjudgmental health care, as well as the need for services accessible to those who speak little or no English.23
• A study of 758 young African American men who have sex with men found that those who carried condoms and reported that their peers normally use condoms were less likely to have unprotected anal intercourse. Therefore, researchers recommend strengthening social norms for condom use among these young men.24

References
1Grov C and Bimbi DS. Race, ethnicity, gender, and generational factors associated with the coming out process among gay, lesbian, and bisexual individuals. Journal of Sex Research 2006; 43(2) 115-121.

Written by Emily Bridges, MLS

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HIV/STI Prevention and Young Men Who Have Sex with Men
The vital importance of reaching the nation’s most at-risk population

Men who have sex with men (MSM) accounted for more than half of all new HIV infections in the United States in 2008. In fact, 85 percent of HIV infections diagnosed in young men ages 13-24 from 2005-2008 were attributed to male-to-male sexual contact. Young men who have sex with men (YMSM) are the only risk group in which the number of new infections has increased steadily each year since the 1990s, even as it has decreased among other populations. Thirty years into the HIV epidemic, young men who have sex with men remain at serious risk of acquiring HIV.

Stigma and historical oppression complicate the problem, placing young men of color who have sex with men at even higher risk: the rate of new infections among this group has risen steadily for 20 years, including a 93 percent rise in new infections between 2001-2006. Each day, nine young African American/black men are diagnosed with HIV.

Without culturally-competent, pragmatic, and inclusive prevention strategies, YMSM are left to explore the realm of sex and sexuality uninformed and through trial and error – leaving them at risk. This document explores the barriers to HIV prevention YMSM may face and provides guidelines for creating more effective prevention programs.

MANY YMSM ENGAGE IN BEHAVIORS THAT PUT THEM AT RISK OF HIV/STIs

• Determining the risky behaviors in which YMSM are likely to engage can inform behavioral interventions in communities of at-risk MSM and secondary prevention efforts among those already living with HIV.

• According to the National HIV Behavioral Surveillance System, 89 percent of YMSM reported anal intercourse with a male partner in the past year and 46 percent had unprotected anal intercourse (UAI). Seventeen percent had UAI with more than one male partner.

• Findings from the same study show that compared to young men who had UAI with only one male partner, those who had UAI with multiple male partners were more likely to have engaged in UAI with a casual male partner. Thirty-one percent of all young men participating in the National HIV Behavior Surveillance System reported drug use during sex.

• One study of YMSM found that the odds of HIV infection increased significantly as the age of sexual partners increased – participants with partners 5 or more years older had twice the odds of becoming infected with HIV than study participants as a whole.

• Many YMSM are not aware of their HIV status. In one nationwide study of MSM which included HIV testing, ten percent of YMSM tested positive, with 69 percent of those who tested positive unaware of being infected with HIV.

• Studies have found that because of the existence of medications which can prolong an HIV positive individual’s life and prevent the virus from developing into AIDS, some YMSM may be taking more sexual risks, including unprotected sex with untested or known HIV positive individuals.

SILENCE, STIGMA, AND DISCRIMINATION CONTRIBUTE TO HIV RISK AMONG YMSM

• YMSM not only face a lack of information about safer sex, but face strong barriers to developing self-efficacy for safer sex behaviors. Stigma against homosexuality leads to a dearth of information and limited discussion about safer sex and HIV prevention.

• All YMSM experience homophobia, through laws and policies that discriminate against them and harmful cultural messages. Most YMSM students have also directly experienced discrimination in schools: 85 percent of GLBTQ students report being verbally harassed in school, and 40 percent report being physically harassed in school.

• GLBTQ youth are overrepresented among homeless youth – comprising between 20 and 40 percent. These youth are more likely to participate in sex work and drug use and have very limited access to health care, placing them at grave risk of HIV.

• Many students encounter misinformation and/or harmful stereotypes in HIV prevention education and sexuality education. Abstinence-only programs often rely on stereotypical gender roles

* YMSM is defined as men ages 24 and under who have sex with other men. This classification is inclusive of those self-identifying as gay, homosexual, bisexual, heterosexual, transgender, questioning, and queer.
YMSM are the only risk group in which the number of new infections has increased steadily each year since the 1990s.

and heterosexual relationships as models, not only ignoring GLBTQ youth, but contributing to stigma against those YMSM who don’t fit a traditionally masculine ideal. Even otherwise comprehensive sex education may fail to provide instruction on risk reduction for GLBTQ youth.

- Other sources of information about safer sex, like parents and health care providers, may not be available to GLBTQ young people. Their parents may not be accepting of their identity or may not be prepared to discuss safer sex for GLBTQ individuals, and many are concerned their health care provider will not maintain confidentiality.
- HIV-related stigma and homophobia are closely linked due to public perception of AIDS as a “gay disease.” One study found that 59 percent of men who had never been tested for HIV had not done so out of fear of negative social consequences. Another found that internalized homophobia was linked to lack of awareness of HIV prevention programs and to a lack of comfort with condom use.

**STRUCTURAL BARRIERS PUT YMSM OF COLOR AT HIGHER RISK**

- For many YMSM, social and economic factors, including homophobia, stigma, and lack of access to culturally competent health care and health care services may increase risk behaviors or be a barrier to receiving HIV prevention services.
- According to the Centers for Disease Control and Prevention (CDC), sixty-three percent of all HIV/AIDS diagnoses among YMSM aged 13–24 in 2008 were among African American/black youth, even though blacks represented only 17 percent of the population in that age group.
- Studies have shown that among men who have sex with men, African American/black men are more at risk for HIV even when they have the same or fewer risk behaviors. An analysis of 53 studies found that black men were not more likely than whites to have unprotected anal sex, engage in commercial sex work, or have sex with a known HIV positive partner; and in fact reported having fewer partners than white men—yet acquire HIV at vastly disproportionate rates.
- A history of oppression of African Americans dating back to slavery, and inequity that continues to the present impact HIV risk for African American youth. Racism contributes to and is intertwined with underemployment and unemployment, decreased access to medical care, and incarceration; these along with social stigma around homosexuality create a strong barrier to sexual health for African American YMSM. For instance:
  - HIV positive black men who have sex with men are less likely than HIV positive white men to be taking ART (anti-retroviral therapy, a group of HIV medications). Because treatment for HIV decreases the viral load, those who are not receiving treatment are more likely to transmit HIV.
  - African American men are four times as likely to be incarcerated as whites; incarcerated men are at risk for unprotected sex and HIV transmission.
  - More than one-quarter of African Americans live in poverty compared to 11 percent of whites. African Americans are less likely that whites to be insured and more likely to have publicly funded insurance.
  - Among YMSM ages 13-24, Latinos experienced 18 percent of new HIV infections in 2008. One study found that cultural expectations play a large role in HIV risk for this population: men who held strong “machismo” (traditionally masculine gender-role) beliefs were more likely to have had multiple partners, while men who had experienced discrimination based on homosexuality were more likely to have had UAI. Latinos are also about twice as likely to have no health insurance as non-Latinos, decreasing their access to health care.
  - American Indians and Alaska Natives represent less than one percent of the total number of HIV/AIDS cases reported to CDC’s HIV/AIDS Reporting System, but their rate of diagnosis of HIV is higher than that of whites (11.9 cases per 100,000 compared to 8.2). Among males, male to male sexual contact accounted for 61 percent of cumulative HIV cases among American Indians and Alaska Natives in 2005 (the most recent year for which this data is available). Many factors, including lack of reporting and cultural barriers to open discussion of homosexual behavior, make understanding the HIV epidemic among this population a challenge.

**EFFECTIVE PROGRAMS, WHICH BUILD SKILLS AND AFFIRM THE VALUE OF YMSM, CAN REDUCE SEXUAL RISK-TAKING**

Complex issues are fueling HIV transmission among YMSM—particularly for YMSM of color. In order to address those complexities, interventions must address individual behavior, and the socio-cultural determinants that fuel HIV transmission.
Peer-based interventions have been effective with YMSM in reducing risk behaviors.

- One intervention with gay men significantly reduced sexual risk-taking behavior in four cities by recruiting popular peers and training them to pass on behavior recommendations to friends through conversation. Surveys found that at one-year follow-up, unprotected anal intercourse in the cities decreased between 15-29 percent, condom use increased, and the number of sex partners decreased.22

- One study found that YMSM were most likely to be reached effectively through outreach activities, such as dances, movie nights, picnics, gay rap groups, and volleyball.23

- One program showed 60 percent fewer YMSM reporting unprotected anal intercourse after sustained sexuality-related peer education that combined education sessions with a social support group.24

- One effective program presented a “menu” of risk reduction options over the course of a retreat weekend, delivered by trained peer facilitators. Compared to those who did not receive the study, participants reduced their number of sex partners and instances of UAI, and were 81 percent more likely to have been tested for HIV six months after the program.25

- Because of the barriers posed by homophobia and racism, interventions for YMSM of color may need to focus on community-building approaches that reflect cultural nuances as well as on individual behavior change. For example, one study suggests that interventions focus on increasing the collective capacity of African American YMSM to address HIV and on increasing tolerance for YMSM within African American communities.26,27

- One study found that programs that promoted positive youth development are paramount to fostering healthy sexual outcomes for youth. The study found that programs that build skills, enhance bonding, strengthen families, engage youth, and empower youth were the most effective at creating behavior change.28

The following critical components for HIV/STI prevention are drawn from research.

- Tailor programs to include YMSM. Programs developed for all young people should discuss sexuality and should include discussion about anal sex in HIV/STD risk reduction sessions.29

- Involve youth. Peer support groups provide non-sexual opportunities for YMSM to share their emotions and experiences, ease their feelings of isolation, and build support systems. Involving YMSM in program design and implementation reduces their risky behaviors and fosters their spirit of self-determination and self-worth.25,30

- Utilize peer influence within social networks. Research has shown that identifying and recruiting peer leaders is an effective way of reaching YMSM with HIV prevention messages.24,25

- Explore new venues, including non-gay-identified ones. Community gathering places, welcoming churches, barber shops and beauty shops, websites, and bars or coffeehouses should be considered as a means of reaching YMSM with prevention messages.31

- Foster a sense of personal worth. Prevention must affirm the value of YMSM and create a context that fosters responsible sexual behavior. One-on-one counseling sessions make effective beginnings for such interventions.2,11,13

- Address the needs of youth. Focus on the needs identified by YMSM, not on those perceived by adults. This may include sponsoring support groups, building dating skills, and providing mentors and other role models.24

- Teach skills. Programs must teach skills. The ability to use condoms, negotiate safer sex with partners, build relationships, communicate with steady and casual partners, make decisions, and say ‘no’ strengthens teens in making healthy choices.29

- Incorporate risk reduction strategies. Programs should include information about partner reduction, gauging one’s own susceptibility, the relative risk of specific behaviors (e.g., anal sex vs. oral sex), and other ways to reduce HIV risk beyond abstinence and condom use.31

- Provide sustained support. Since sustaining behavior change is difficult, populations at high risk require continuing support and reinforcement. To prevent relapse into unsafe behavior, prevention programs must address the changing needs of YMSM as they grow older.

- Create programs specifically for YMSM of color. Studies indicate that programs need to address individual, community, and cultural factors pertinent to YMSM. Programs should address racism in the gay, white community

YMSM face not only a lack of information about safer sex, but a strong stigma against discussing their sexuality.
High infection rates in the community mean that even with equal or fewer risk behaviors, YMSM of color are more likely to acquire HIV.

while simultaneously supporting YMSM of color as they deal with decisions regarding sexuality, gay identity, culture, and race/ethnicity. YMSM also need safe environments for sharing their experiences.29

- **Address the needs of marginalized groups such as homeless youth and IV drug users.** Programs must reach out to homeless youth, especially those involved in commercial sex, and those who are IV drug users. One study of homeless adolescents found that one in 14 had been treated for AIDS. An estimated one-third of homeless youth have participated in survival sex or sex work. Homeless youth are also more vulnerable to intravenous drug use (IDU), a risk factor for HIV transmission. And in 2006, thirteen percent of new HIV infections among males were attributed to IDU or male sexual contact and IDU. This highly at-risk population desperately needs outreach programs and basic health care.1,9

Importantly, interventions which focus solely on changing personal behaviors are only a part of a successful HIV prevention strategy. Addressing other factors which contribute to the spread of HIV is vital. Recommendations drawn from research include:

- **Support structural interventions (approaches that promote health by changing the environment to one that facilitates health), including ones which work toward:**
  - Condom availability and comprehensive sex education, including risk reduction in schools and other community settings/venues.
  - 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.
  - Harm reduction, including needle exchange legislation and programs for injection drug users.
  - Community mobilization for HIV prevention advocacy and a reduction of stigma against HIV positive individuals
  - Ensuring access to quality education and health care
  - Routine HIV testing
  - Reducing the community viral load through early diagnosis of HIV infection, timely initiation of antiretroviral therapy, and treatment adherence.
  - Supporting policies protecting against hate crimes and employment discrimination based on sexual orientation.32

- **Adopt an ecological approach to prevention.** An ecological approach attempts to create more effective and culturally competent programs by examining a young person’s entire sphere (their family, community, and societal relationships and influences) and creating peer, group and family-level interventions.32

**CONCLUSION**

HIV remains an incurable and life-threatening disease, and one for which young men who have sex with men are highly at risk. Like all young people, YMSM need culturally-competent, pragmatic, and inclusive prevention messages – as well as programs which address behavioral, cultural, and institutional barriers to sexual health information and services.

Written by Durryle Brooks, Program Manager, GLBTQ Initiatives, and Emily Bridges, Director of Public Information Services

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**REFERENCES**


Changing personal behaviors is only a part of a successful HIV prevention strategy. Youth need programs which foster a healthy, empowering environment.
MISSION
Established in 1980 as the Center for Population Options, Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health.

OUR VISION: THE 3RS
Advocates for Youth envisions a society that views sexuality as normal and healthy and treats young people as a valuable resource.

The core values of Rights. Respect. Responsibility® (3Rs) animate this vision:

RIGHTS: Youth have the right to accurate and complete sexual health information, confidential reproductive and sexual health services, and a secure stake in the future.

RESPECT: Youth deserve respect. Valuing young people means involving them in the design, implementation and evaluation of programs and policies that affect their health and well-being.

RESPONSIBILITY: Society has the responsibility to provide young people with the tools they need to safeguard their sexual health, and young people have the responsibility to protect themselves from too-early childbearing and sexually transmitted infections (STIs), including HIV.

SOME RELATED PUBLICATIONS FROM ADVOCATES FOR YOUTH

The Facts: GLBTQ Youth
The Facts: Young Men who Have Sex With Men
Issues at a Glance: Adolescent Sexual Health and the Dynamics of Oppression

See the complete library of publications at www.advocatesforyouth.org/publications
Young Men:

- A study released by the University of California Los Angeles (UCLA) in 2003 found that almost half (45.7%) of young (between ages of 13 and 23) gay and bisexual men living with HIV reported being sexually abused before age thirteen.\(^1\) In a separate study, Finkelhor reported that only 3% to 4.8% of the general male population received such abuse.\(^2\)

- The above UCLA study found that 42% of young gay and bisexual men living with HIV reported ever attempting suicide.\(^3\) In contrast, the National Longitudinal Study on Adolescent Health found that only 4% of all youth reported attempting suicide in the past year.\(^4\)

- The 2003 UCLA study of young men living with HIV also reports that only 47.9% of gay men and 49.3% of bisexual men report always using condoms since learning of their HIV positive status.\(^5\)

- A California State University study released in 2002 of gay-identified men in four U.S. cities indicates a relationship between “coming out” at a young age and educational level. The study shows that young men who decide they are gay before age 17 are only 79% as likely to earn a Bachelor’s Degree as those who

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decide they are gay after age 22. Young men who decide they are gay between the ages of 18 and 21 are only 57% as likely to earn a Bachelor’s. Young men who become sexually involved with other men before age 17 and between the ages of 18 and 21 are also less likely to earn a college degree than their counterparts who do not engage in intra-male sexual behavior until after age 22 (50% and 67%, respectively).6

- Research released in 2002 derived from a secondary analysis of the 1995, 1997, and 1999 Massachusetts Youth Risk Behavior Study (MYRBS) shows that young men who have sex with both men and women are only 36% as likely to report condom use than young men who have sex with female partners exclusively. These young bisexual men are also nearly three times as likely as heterosexual young men to report having four or more lifetime sexual partners.7

- According to research taken from a 2000 Community Intervention Trial for Youth (CITY) project, young bisexual-identified Latino men were more likely to report multiple male partners in the prior three months than their gay-identified peers (77% vs. 57%). Moreover, Latino bisexual men were about 3.5 times more likely to report unprotected insertive anal sex than Latino gay men.8

- A study released by the New York Blood Center in 2000 reveals that almost half (46.1%) of young men who have sex with men reported having unprotected anal sex with another man in the previous six months. Furthermore, most of these men reported unprotected oral sex.9

- In 2000, the Center for AIDS Intervention Research at the Medical College of Wisconsin released the results of a qualitative study concerning ways to improve HIV prevention programs. One respondent to this study, a YMSM, stressed the importance of a LGBT youth center: “There should be a community center. There is nothing for kids here. We need a place where kids can hang out with adult supervision. A place where you can still be a kid and gay. When you are a kid and realize that you are gay, you are thrown into an adult world because you are gay. There is no world for gay kids.”10

- In a study conducted by the University of California at San Francisco in 1999, only 48% of Asian and Pacific Islander YMSM reported using a condom every

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time they had anal sex. 8% reported not using a condom with two or more partners in the previous 3 months.11

- A national study of LGBT college students conducted by Western Kentucky University over the 2001-2002 academic year found that only one in three (35.6%) of gay, bisexual, and transgender men in college reported using a condom during their most recent sexual encounter.12

- A 2000 study by the Violence Prevention Consulting Group in Boston showed that more gay-identified young men report experiencing abuse from a date or romantic partner than straight young men (44.6% vs. 28.6%).13

**Young Women:**

- In a Pennsylvania State University study released in 2003, 75% of young lesbian and bisexual women reported receiving verbal abuse in their lifetime. Moreover, 30% reported having been physically threatened, 13% reported physical assault, and 12% reported sexual assault.14

- The same study shows that 14% of young women who have sex with women reported verbal abuse and 7% reported physical abuse from their mothers due to their sexual orientation.15

- In a study released by Washington University in 2002, 28% of young women who dated only other women reported verbal and physical abuse from a date or romantic partner. Almost half (44%) of young bisexual women reported the same.16 In contrast, the Youth Risk Behavior Study found that only 9.23% of all young women report dating violence.17

- According to a study released by the University of Washington and the University of Minnesota in 1999, bisexual or lesbian young women reported higher rates of pregnancy (12% vs. 5.3%), physical abuse (19% vs. 12%), and sexual abuse (22% vs. 15%) than heterosexual female adolescents.18

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• Research released by the San Francisco Department of Public Health shows that lesbian and bisexual women are significantly more likely to report recent and lifetime use of all categories of drugs and alcohol than their heterosexual peers. Bisexual and lesbian women are also more likely than their heterosexual peers to report being forced to have sex (50% vs. 23%), trading sex for money or drugs (34% vs. 6%), and being threatened with force to have sex (55% vs. 25%).

• The same study shows that bisexual women are even more at-risk than lesbians within the sexual minority population. Bisexual women were significantly more likely to report trading sex for money or drugs than lesbians (41% vs. 18%).

• In a 2001-2002 national study conducted by Western Kentucky University, only one in five (20.2%) lesbian and bisexual women in college reported using a barrier during their most recent sexual encounter.

• In a 2000 study conducted by the Violence Prevention Consulting Group in Boston, lesbian-identified young women reported experiencing abuse from romantic partners or dates in higher numbers than straight women (43.4% vs. 32.4%).

Young Transgender Individuals:

• A 2001 qualitative study released by the University of Hawaii reveals the benefit of groups that provide services to transgender youth. One transgender respondent linked her academic aspirations to a role model she met through the group: “April is a transsexual like me. She relates more with us, and that makes me feel even more assured... She’s a successful woman, and it makes me feel like there is hope for me. ... I plan to go to [college] and major in cosmetology or architecture; my goal is to be successful.”

• Another respondent in the same study credited a social worker and the support group, Chrysalis, with building her self-esteem and steering her away from life-threatening behavior: “I was feeling like killing myself because of the way people treated me, the way they talked behind my back. I told April all of this, and she helped me... She helped bring me up to a higher level, and I’m really thankful for how she helped my life. If I didn’t have her, I would be dead or in the hospital. The truth is one time I tried to OD on pills and ended up in the hospital for a few days because I didn’t like my life. I wanted to dress like this, and people would tease me for it. It was really hard. Chrysalis helped me understand myself.”

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• In the Gay, Lesbian and Straight Education Network’s 2003 national study, 81.3% of transgender-identified high school students report experiences of verbal harassment due to their gender expression, compared to 46.7% of gay and bisexual young men and 35.9% of lesbian and bisexual young women. Moreover, 23.8% of transgender students report physical harassment (vs. 19.5% of gay and bisexual young men and 11.3% of lesbian and bisexual young women) and 10% report physical assault due to their gender expression (vs. 8.5% of gay and bisexual young men and 2.3% of lesbian and bisexual young women).25

• The 2003 Gay, Lesbian and Straight Education Network School Climate report also reveals that 36.3% of transgender-identified high school students reported feeling unsafe in their school environment due to their gender, while only 2.7% of young gay and bisexual men and 13.3% of young lesbian and bisexual women reported the same. More than three out of four transgender students (78.8%) reported feeling unsafe in school due to their gender expression, as compared with 41.4% of gay and bisexual male youth and 29.8% of lesbian and bisexual female youth.26

• A survey of transgender adolescents in an LGBT alternative high school in 2000 provides insight into the difficulties these individuals face in their school environments. One respondent, Cassandra, details the resistance she met in transitioning: “In junior high school, when I decided I wanted to be a girl, my teachers gave me a hard time because I was growing nubs for some reason. I don’t know why. They were like, oh, we can’t call you a different name. And we have to call you he and this, that, and the third. And it really hurt me, you know, I’m trying to be something else and they’re bringing reality into my face and it really bothered me a lot.”27

LGBT Youth:

• A study of homeless youth in one south central U.S. city released in 2005 by the University of Texas in Austin shows that 73% of homeless lesbian and gay adolescents and 25.6% of self-identifying bisexual homeless youth reported parental disapproval of their sexual orientation as a reason for their homelessness.28

• Research released in 2000 based on the Centers for Disease Control and Prevention’s Homeless and Runaway Youth Survey reveals that 46% of gay and bisexual young homeless men and 23% of lesbian and bisexual young homeless women reported exchanging sex for money, drugs, and other needs.29

• The University of Washington’s study of homeless youth in Seattle, released in 2002, further indicates the increased risks encountered by LGBT adolescents. Homeless LGBT youths reported leaving home more often than their heterosexual peers (mean of 12.38 times vs. 6.69 times). Homeless LGBT youth also reported being sexually victimized by more people since becoming homeless than their heterosexual peers (mean 8.61 perpetrators vs. 1.24).30

• In a study of LGB adolescents living in the U.S., Canada, and New Zealand released by Pennsylvania State University in 2001, more than one in four reported attempting suicide by age sixteen, and most (57%) of those reported a link between their suicide attempt and their sexual orientation.31 In contrast, the National Longitudinal Study on Adolescent Health found that only 4% of all youth reported attempting suicide in the past year.32

• One in ten (10%) LGBT youths in the same Pennsylvania State University study reported attempting suicide within the past year. Of these, 34% reported needing emergency care after the attempt.33

• In a regional study of LGB youth in the Southeast released by Georgia State University in 2000, less than half (47%) of LGB youth reported ever being tested for HIV. Of the same group, more than one in three (36%) reported ever having unprotected anal sex and most (79%) reported ever having unprotected oral sex. Additionally, more than one in four (28%) reported ever having unprotected vaginal sex.34

• The 2003 Massachusetts Youth Risk Behavior Survey (MYRBS) found that LGB youth were more likely to report smoking currently (48% vs. 19%) and on a daily basis (23% vs. 6%) than the general student population. Additionally, more sexual minority youth reported current alcohol use (60% vs. 45%), binge drinking (44% vs. 26%), and current drug use (49% vs. 29%). Most LGB youth reported lifetime drug use, compared to less than half of the general student population (73% vs. 46%).35

• The 2003 MYRBS also shows that 30% of sexual minority youth reported dating violence (compared to only 9% of other students) and 41% reported nonconsensual sexual contact (compared to only 8% of other students).36

• The Gay Lesbian and Straight Education Network’s 2003 study of LGBT youth in school shows that 91.5% of GLBT youth reported often hearing derogatory homophobic remarks in school. And though most (70.8%) of LGBT students reported that these remarks were distressing to them, even more (82.9%) reported that school faculty sometimes or never intervened when these comments were made in their presence.37

• A study released by the City University of New York in 2002 of LGBT adolescents in New York City showed that bisexual-identified youths reported more discomfort with homosexuality and negative attitudes toward homosexuality than their gay- and lesbian-identified peers.38

• A 2001-2002 Western Kentucky University study of LGBT college students in the United States showed that almost all (89.2%) reported never using a condom or barrier for oral sex. Only 4% reported using a barrier consistently for oral sex.39

• According to the same Western Kentucky University study, only 38.2% of LGBT college students (between the ages of 18 and 24) reported ever being tested for HIV,40 while a study at Florida Southern College found that 45.7% of the general college student population reported having been tested for HIV.41

• In a 2005 study of LGBT youth and tobacco use conducted by the University of Minnesota Youth and AIDS Project, two-thirds of the respondents were smokers (compared to only 11.7% of all middle-school students and only 28.0% of all high school students, according to the CDC’s National Youth Tobacco Survey42). When the LGBT youths were asked how to build an effective tobacco prevention program, “many of the respondents discussed the general importance of building social support for nonsmoking and bolstering individuals’ self-esteem and positive identification within the LGBT community.” One gay youth commented on the importance of LGBT adults in discouraging LGBT youth from smoking: “I think commercials would work if they changed them and just zoomed in on GLBT youth. I think that would actually work if they had messages of older GLBT people saying—they smoked when they were younger and these are the effects and tell them how serious smoking is. . . . The key element is that the commercial would be all GLBT people.”43

Young Women Who Have Sex with Women: Falling through Cracks for Sexual Health Care

Health educators often assume that young women who have sex with women (YWSW)* are at little or no risk for HIV, other sexually transmitted infections (STIs), and unintended pregnancy when, in fact, risk behaviors and barriers to health care put YWSW at risk for all three. Health care professionals and researchers often tell YWSW that they are “safe.” Moreover, the sexual health needs of young women of color who have sex with women go mostly unrecognized. YWSW need information and programs that specifically address their complex needs and that encourage them to protect themselves.

YWSW Are at Risk for HIV, Other STI, and Pregnancy.

Some women who have sex with women (WSW) are uncomfortable with routine gynecological care, including PAP smears and STI screening. Yet, they are at risk for STIs. In a nationwide study of 6,935 self-identified lesbians, 17.2 percent reported a history of STI. In another survey of lesbian and bisexual women, 26 percent reported a past STI. Human papillomavirus occurred among 30 percent of surveyed WSW, including 19 percent of women who had sex only with other women. Infection with genital herpes, chlamydia, gonorrhea, and syphilis, while not much studied in WSW, may be likely, depending on the women’s sexual practices. Safer sex information seldom covers protective methods for oral or manual sex, encouraging the myth that YWSW are not at risk for STI. Only the lesbian community receives such health promotion information; and many YWSW, especially young women of color, may not identify with the lesbian community.

“Underreporting of HIV among lesbians seems likely given that many women are reluctant to acknowledge their sexual orientation to their doctor.” The Centers for Disease Control (CDC) does not gather data on the exposure category of female-to-female HIV transmission and, therefore, lacks YWSW epidemiological data. Through December 1998, 109,311 AIDS cases occurred among U.S. women. Information on female-to-female exposure was missing in half of these cases. At the same time, 98 percent of the 347 women who reported having sex only with other women also reported other risk behaviors, such as injection drug use.

Many YWSW also have sexual intercourse with men, including men who have sex with other men. Unprotected intercourse with men may place YWSW and their female partners at risk for HIV. In a survey of 6,935 self-identified lesbians, 77.3 percent reported sex with one or more male in their lifetime, including vaginal (70.5 percent) and anal (17.2 percent) intercourse. In a study in New York City, 32 percent of lesbian and bisexual young women reported sex with at least one gay or bisexual man; 51 percent reported having sex with at least one high risk partner.

Sexual intercourse with young men also puts YWSW at risk of unintended pregnancy. One study showed that, while bisexual and lesbian teenage females were about as likely as heterosexual peers to have had intercourse, they reported twice the rate of pregnancy (12 percent) as heterosexual and questioning young women (five to six percent). A higher percentage of lesbian and bisexual young women also reported sexual intercourse daily or several times each week and no use of contraception compared to their heterosexual and questioning counterparts.

* In this paper, YWSW refers to sexual behavior. The terms lesbian and bisexual are used here with reference to studies of women who self-identify in this way.
Health Care Providers and Researchers Overlook YWSW, Despite Risk Factors.

Studies show that adult lesbians, fearing discriminatory and negative responses from health care providers, seek out health care services less often than heterosexual women. When they seek out health care, they may volunteer incomplete or inaccurate information about themselves. One qualitative study of eight lesbian youth in San Francisco suggested they share many of the fears of adult lesbians and experience ignorance, insensitivity, and heterosexism from health care providers. Some face bias because their gender and gender presentation are incongruent. For YWSW, these problems are compounded by discrimination based on their youth.

Moreover, research indicates that health care providers take incomplete sexual histories, assuming (often inaccurately) that YWSW who identify as lesbian have not had sex with men and have not participated in sexual risk behaviors. Providers may inaccurately assume that YWSW are “too young” to identify as lesbian or to participate in risk behaviors. These assumptions cause providers to overlook or ignore the realities of life for YWSW.

Health care providers and researchers often overlook YWSW altogether. For example, the CDC’s lack of a formal category for female-to-female transmission of HIV ensures that this potential mode of transmission will remain unevaluated. Little research is conducted around YWSW, and there is a lack of prevention messages targeted towards these youth. Lesbian health research usually addresses the needs of adult women. Research on GLBTQ (gay, lesbian, bisexual, transgender, and questioning) youth usually focuses on gay youth or young men who have sex with men. Finally, researchers have almost totally ignored the needs of young women of color who have sex with women.

This lack of concern and attention carries inaccurate messages to YWSW. Even though 26 percent of lesbians in a recent survey had an STI at some point in their lifetime, 84 percent of respondents believed that, during the previous year, they were at zero risk for HIV and STI. Only 21 percent had ever suggested safer sex practices to a sexual partner. YWSW need accurate, age-appropriate, and culturally sensitive information about sexuality and sexual health.

YWSW Face Complex Mental, Physical, and Sexual Health Care Issues.

Providing accurate information about HIV, STI, and pregnancy prevention is only part of the picture for ensuring sexual health among YWSW. Effective programs must address the many factors that contribute to sexual risk behaviors among YWSW.

- **Access to Health Insurance**—Some YWSW lack health insurance or easy access to publicly subsidized services. For example, lesbians with long term-partners are often ineligible for coverage under a partner’s policy, and many YWSW have jobs that offer limited or no health insurance. Demand can be high and lines long at subsidized clinics that serve homeless youth, women, and GLBTQ youth, rendering these clinics less accessible to clients, including YWSW.

- **Cultural and Family Attitudes**—Many YWSW receive little support at home or in their communities due to cultural and familial attitudes that being GLBTQ is unhealthy or unacceptable. Almost three-fourths of respondents in the National Lesbian Health Care Survey (n=1925, including 200 youth) had received counseling; half cited sadness and depression as the reason for seeking therapy. Many GLBTQ youth are kicked out of their homes because of their sexual orientation. Estimates of GLBTQ youth’s homelessness vary, but service providers agree that rates are high and that sexual orientation is the reason for homelessness among 20 to 40 percent of all homeless youth.

- **Racism and Homophobia Combined**—Youth of color face additional challenges. As within society as a whole, homophobia is common within communities of color. Young women of color who have sex with women face challenges of sexism, racism, and homophobia from society as a whole, the white lesbian community, and their individual communities of origin. In addition, HIV infection is rising sharply among young women of color; half of new HIV infections occur among people ages 15 to 24; and three-quarters of cumulative AIDS cases among youth are occurring among African American and Latina women.
• **Assault and Abuse**—A history of physical and/or sexual abuse by family members and assault by fellow students, strangers, and acquaintances are frequently reported in studies of young lesbian and bisexual women. In one survey, 19 percent of bisexual or lesbian respondents reported a history of physical abuse compared to 11 to 12 percent of heterosexual or questioning adolescents. In another study, lesbian and bisexual young women were significantly more likely to report having been sexually abused than were heterosexual or questioning women – 22 percent versus 13 to 15 percent, respectively.

• **Substance Abuse**—Substance use is a risk behavior that research has frequently found to cluster with other risk behaviors, including unprotected sexual intercourse. Research also suggests that GLBTQ youth are twice as likely to use alcohol, three times more likely to use marijuana, and eight times more likely to use cocaine/crack compared to heterosexual youth. In one survey, one-third of lesbians reported smoking daily and thirty percent, drinking alcohol more than once a week.

• **Commercial or Survival Sex**—One study indicated that lesbian and bisexual teenage women were five times more likely to have exchanged sex for money, food, or other necessities than were their heterosexual or questioning peers (10 percent versus two percent, respectively).

**Sexual Health Programs Should Target the Health Needs of YWSW.**

YWSW need comprehensive health care services and sexual health messages that address their specific needs. One study found that young lesbian and bisexual women are more likely to use health care clinics for routine health and wellness checkups if the clinics are culturally sensitive to young women’s needs. Services and sexual health programs that adequately address the needs of YWSW include the following components:

• **Accurate and reliable resources and materials**—Brochures regarding the sexual health of YWSW are available to all youth served by the program. Programs offer information about YWSW and are developed specifically for YWSW.

• **Culturally competent staff and volunteers**—Programs familiarize staff and volunteers with the needs of YWSW and train them to be nonjudgmental, use inclusive language (such as “sexual partner” and “same-gender sexual behavior”), and make no assumptions about youth’s behavior.

• **Programming developed and led by youth**—Programs empower young people to train and develop support groups for other young people, allowing the programs to focus on the needs identified by young women rather than on needs perceived by adults. Peer-led programming limits young women’s isolation and encourages them to build leadership skills and provide other YWSW with support.

• **Opportunities to build skills**—Effective programs promote and encourage skills, such as developing healthy relationships, negotiating safer sex with partners, using condoms and dental dams, communicating with steady and casual partners, and saying “no” to unwanted sex.

• **Programs specific to young women of color who have sex with women**—Programs support the young women as they deal with decisions and issues regarding sexuality, identity, gender identity, culture, race/ethnicity, and racism.

• **Programs for specific populations of YWSW**—Programs reach out to homeless youth, including sex workers, first addressing their needs for food, clothing and shelter, and then focusing on health considerations. Versed in issues of gender identity, programs provide support for transgender youth.

**Recommendations to Improve the Health of YWSW**

More research is needed to discern the sexual health needs of young women—particularly young women of color—who have sex with women. Much completed research has never been published. For example, Boston’s Fenway Community Health Center studied the needs of lesbians of color. This and other studies should be published in professional, peer-reviewed journals. Finally, the CDC needs to assess accurately and systematically the risk for HIV infection facing YWSW. The health of YWSW can improve dramatically with support from medical, public health, and education professionals.
References


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