The Sexual and Reproductive Health of Young Men of Color: Analyzing and Interpreting the Data

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The Joint Center for Political and Economic Studies
Health Policy Institute

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Executive Summary

Introduction

Historically, the focal point of the discourse on the sexual and reproductive health of adolescents has been teen pregnancy, and the population of interest has been adolescent females ages 10-14 and ages 15-19. Issues related to the sexual and reproductive health of young males were seldom considered, as reflected in the type of data collected—or not collected—for male and female teens. In the late 1980s, this began to change with an increased emphasis on issues related to male teens, in part due to the spread of infections such as HIV (human immunodeficiency virus) and chlamydia. Our knowledge about the sexual and reproductive health outcomes and behaviors of young men of color (Hispanic or Latino, black or African American, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander) is shaped by the methods used to gather and analyze the relevant data. These methods and the resulting data, however, do not always accurately reflect trends for this group. This report traces our knowledge about the sexual and reproductive health of young men of color from outcomes to behaviors, and then discusses some of the complexities associated with studying this population.

Outcomes

The sexual and reproductive health of young men of color can be assessed by examining various outcomes, such as impregnation rates and rates of sexually transmitted infection, HIV infection, and AIDS. These outcomes—the result of choices made by young men of color about sexual activity and behaviors—are the starting point for this report.[1]

- In recent years, the share of male high school students who reported having ever impregnated a female has declined markedly. About half as many black non-Hispanic, Hispanic, and white non-Hispanic male high school students reported having ever impregnated a female in 2003, compared with 1995. In 2003, nearly eight percent of black non-Hispanic, more than five percent of Hispanic, and nearly two percent of white non-Hispanic male high school students reported having ever impregnated a female.

- Among males ages 15-29, between 1999 and 2004, black non-Hispanic males reported the highest rates of infection for chlamydia, gonorrhea, and syphilis, three of the most common sexually transmitted infections.

- Peak rates for chlamydia, gonorrhea, and syphilis are reported at different ages for young males of all racial/ethnic groups. Between 1999 and 2004, chlamydia and gonorrhea rates were higher among young men ages 20-24 than among males ages 15-19 and 25-29. Syphilis rates were highest among 25- to 29-year-olds in 2004, although in 1999, the peak rates were reported among males ages 20-24.

- Between 1999 and 2004, chlamydia rates increased for all young men ages 15-29. Among 15- to 19-year-olds, rates increased most among black non-Hispanic males (by 37 percent). Among young men of color ages 20-24 and 25-29, rates increased the most among American Indians/Alaska Natives, rising by 89 percent and 98 percent, respectively.

- Gonorrhea rates fell significantly between 1999 and 2004 among young black non-Hispanic males in the three age groups between 15 and 29 years. Despite the decline, gonorrhea rates for black non-Hispanic males remained significantly higher than those for young men of other racial/ethnic

[1] Data reported represent different years because of the complexities associated with collecting data for the young men of all the racial/ethnic groups of interest.

groups. For example, although rates declined 29 percent for black men ages 15-19 (from 1,964.8 per 100,000 to 1,390.1 per 100,000), their 2004 gonorrhea rate was more than 10 times the second highest rate (137.4 per 100,000) among American Indian/Alaska Native males.

■ Although syphilis rates among most young men of color exhibited an increasing trend between 1999 and 2004, this rate declined among young black non-Hispanic men ages 15-19 and 20-24. Even with this decline, rates for black non-Hispanic males remained three times those of Hispanic young men, the group with the second-highest rates in most years.

■ Young black non-Hispanic men were overrepresented—and men of other racial/ethnic groups were underrepresented—among cases of HIV infection and AIDS in 2001. This overrepresentation is most striking among young men ages 13-19. Although black non-Hispanic males were less than 15 percent of this age group, they accounted for 59 percent of cases of HIV infection and 40 percent of AIDS cases diagnosed in 2001 among this cohort.

Behaviors

Undesired reproductive health outcomes often result from risky behaviors in which young men of color may engage. These behaviors include having unprotected vaginal intercourse or engaging in other types of unprotected sexual activity (such as oral or anal sex), having multiple sexual partners, making an early sexual debut, and using alcohol or drugs during sexual activity.[2]

Experience with Sexual Intercourse

■ Between 1993 and 2003, the proportion of high school young men of color who ever had sexual intercourse (i.e., vaginal intercourse) declined notably. Rates declined nearly 18 percent among white non-Hispanic male students (from 49 percent to 41 percent), more than 17 percent among black non-Hispanic male students (from 89 percent to 74 percent), and nearly 11 percent among Hispanic male students (from 64 percent to 57 percent). Between 1997 and 2001, rates declined nearly eight percent (from 71 percent to 66 percent) among American Indian male students.

■ In 2002, young males ages 18-19 were twice as likely as males ages 15-17 to have had sexual intercourse (nearly 65 percent compared with nearly 32 percent). This gap narrows for black non-Hispanic males (79 percent versus 53 percent) and for Hispanic males (70 percent versus 43 percent).

■ Although a majority of high school young men of color have had sexual intercourse, smaller proportions are currently sexually active (defined as having had sexual intercourse in the past three months). In 2001, 52 percent of black non-Hispanic, 44 percent of American Indian, 37 percent of Hispanic, and 30 percent of white non-Hispanic male high school students reported current sexual activity.

Age at Sexual Debut

■ In 2001, black non-Hispanic male high school students were the most likely (26 percent) to report having had sexual intercourse before age 13. In comparison, 17 percent of American Indian, 11 percent of Hispanic, and six percent of white non-Hispanic male students reported the same.

[2] As noted in the section on outcomes, data reported represent different years because of the complexities associated with collecting data for young men of all the racial/ethnic groups of interest.

Number of Sexual Partners

■ In 2003, black non-Hispanic male high school students were the most likely (42 percent) to report having had four or more sexual partners during their lifetimes. White non-Hispanic male students were the least likely (12 percent) to report four or more partners, while Hispanic male students were half as likely (21 percent) as black non-Hispanic males to report the same.

Use of Contraceptives

■ According to a 2002 survey, condoms are the contraceptive preferred by young men ages 15-24, and young black non-Hispanic men are the most likely to use condoms. Nearly 95 percent of young black non-Hispanic men reported using condoms at least some of the time, compared with 84 percent of both Hispanic and white non-Hispanic young men.

■ Although a majority of young men do not use condoms every time they have sexual intercourse, more than two-thirds of young men ages 15-19 of all racial/ethnic groups reported using condoms during their first sexual intercourse, according to a 2002 survey.

■ In 2001, a majority of male high school students who reported having had sexual intercourse in the preceding three months reported that they had used a condom during their last sexual experience—73 percent of black non-Hispanic, 65 percent of American Indian, 64 percent of white non-Hispanic, and 59 percent of Hispanic male high school students.

Alcohol or Drug Use during Sexual Intercourse

■ In 2003, although sizable minorities of young men of color reported drug or alcohol use with their last sexual intercourse, black non-Hispanic male high school students were less likely to report drug or alcohol use (24 percent) than their white non-Hispanic and Hispanic counterparts (31 percent and 30 percent, respectively).

Other Types of Sexual Intimacy

■ In addition to vaginal sexual intercourse, young men also engage in other types of sexual activity, such as oral sex and anal sex. In 2002, comparable proportions of males ages 15-24 of the major racial/ethnic groups reported having participated in oral sex (given or received) with a female partner—nearly 71 percent of white non-Hispanic, 69 percent of black non-Hispanic, and 67 percent of Hispanic males.

■ In 2002, more than 28 percent of Hispanic males ages 15-24 reported having had anal sex with a female, compared with nearly 25 percent of black non-Hispanic and nearly 20 percent of white non-Hispanic males ages 15-24.

■ In 2002, small percentages of young men of color reported same-sex sexual contact; between five and six percent of black non-Hispanic, Hispanic, and white non-Hispanic males ages 15-24 reported having had same-sex oral or anal sex.

Challenges in Interpreting Sexual and Reproductive Health Data

Our knowledge about the sexual and reproductive health of young men of color is filtered through a mesh consisting of several elements. Numerous data collection complexities that can be readily enumerated, if not addressed, comprise one of these elements. Broader societal factors, such as racism and the media, represent another element, but one whose influences can be less clearly described. These and other elements that shape our knowledge of the sexual and reproductive health of young men of color are discussed in this section of the report.

Data Collection

■ Neuroscientific findings about the development of the adult brain, coupled with an increase in the age at first marriage and changes in marriage/cohabitation patterns, suggest the need to examine the sexual and reproductive health of adolescents as well as young adults (e.g., the age cohort of 13-29).

■ The quality and accuracy of information collected about the sexual and reproductive health of young men of color are shaped by decisions about the size and diversity of the populations surveyed to gather this information. Data collection also is influenced by external factors (e.g., insurance coverage and poverty) that affect the enumeration of outcomes (e.g., cases of STIs reported by public health clinics).

■ Although females and teen pregnancy historically have been the foci of adolescent sexual and reproductive health research, since the late 1980s a number of behavioral surveys either have targeted men exclusively (e.g., the National Survey of Men and the National Survey of Adolescent Males) or have expanded their samples to include males (e.g., the National Survey of Family Growth, in 2002).

■ As a rule, behavioral surveys about sexual and reproductive health provide little information about young men of color who are neither African American nor Latino. Information about young males who are Asian, Native Hawaiian and Other Pacific Islander, and American Indian or Alaska Native is sparse. The findings that exist are frequently not generalizable because they are based on small samples or on non-random samples (e.g., American Indians attending schools funded by the Bureau of Indian Affairs).

■ Sample surveys (i.e., surveys of population samples) are conducted primarily to learn about behaviors that influence sexual and reproductive health outcomes. Reliance upon self-reports in these surveys (although quite likely unavoidable) comes with known biases due to male exaggeration—and female understatement—of their sexual acumen and experiences.

■ Findings from cross-sectional surveys—that is, surveys conducted at a single point in time—dominate the research literature about the reproductive and sexual behavior and health of adolescents. Cross-sectional surveys, however, often are difficult to compare because of methodological differences. They also do not provide insights into the causes of behaviors because they reflect a single point in time, rather than tracking behavioral trends over time.

■ Outcome data (primarily on STIs) for young men of color are likely to be biased because disease case reports are captured within the nation's public health system more often for people of color than for whites. This occurs because lower-income populations are more likely than higher-income populations to use local public health clinics, and because people of color are more likely than whites to be poor.

■ Sexual and reproductive health outcome data are not consistently reported for all categories of race by age and by gender. Thus the outcome data reported for young men of color in this report are older (by several years in some cases) than the comparable data available for all men or for all people of color.

■ Behavioral survey data and outcome data for young men of color taken together sometimes yield puzzling findings. For example, young African American males self-report the most consistent condom use (i.e., a behavior), along with the highest rates of three common STIs (i.e., outcomes).

Macro Influences

■ Although research has not yet unraveled the relationship between societal racism and adolescent sexual and reproductive health behaviors and outcomes, the identification of linkages between racism and general population health, as well as between racism and youth development, suggests that racism plays a similar role with adolescent sexual and reproductive health.

■ Phenomena such as "sociologic ghosts" and acculturation have multidimensional influences on the sexual and reproductive health behaviors and outcomes of young men of color.

■ Sex education is provided in school settings too late for some young males of color to benefit from it before their sexual debuts.

■ The influence of a mother working outside the home on a young male's age at his sexual debut and on the extent of his sexual activity varies for young men of different racial/ethnic groups, depending on age cohort and research methodology. The same holds true for the influence on these outcomes of the presence of a father/stepfather in the home.

■ The top two reasons that African American and Latino males ages 15-19 give for never having had sexual intercourse are "not wanting to get a female pregnant," followed by "religion or morals."

Introduction

In 2005, an estimated 34.2 million males and 33.3 million females in the United States were between the ages of 13 and 29, the primary age cohort used in this report to define "young." Males were nearly 51 percent of these young people, and young men of color were 51 percent of all young people of color.[3] Although white males (62.5 percent) constitute the majority of males ages 13-29 in the United States, the remaining 37.5 percent represents 12.8 million young men of color.[4] These young men of color are primarily Hispanic or Latino and black or African American; nearly 6.5 million are Hispanic or Latino males (50 percent of young men of color) and 4.6 million are black or African American males (nearly 36 percent of young men of color). Other young men of color include 1.4 million Asian Americans (11.3 percent of young men of color), more than 90,000 Native Hawaiian and Other Pacific Islander males (less than one percent of young men of color), and nearly 205,000 American Indian and Alaska Native males (1.6 percent of young men of color). Like males of color of all ages, these young men face unique challenges and health issues.[5]

Historically, the focal point for the sexual and reproductive health of adolescents has been teen pregnancy, and the population of interest has been adolescent females ages 10-14 and ages 15-19. Issues related to the sexual and reproductive health of young males were seldom considered, as reflected in the type of data collected—or not collected—for male and female teens. In the late 1980s, this began to change with increased interest in and emphasis on issues related to male teens, in part due to the spread of infections such as HIV (human immunodeficiency virus) and chlamydia. This interest has been reflected in expanded collection of data about young men—both in male-only surveys and in surveys including males and females. The collection and analysis of these data have shed some light on the sexual and reproductive health outcomes and behaviors of young men of color. At the same time, however, decisions made during the collection and analysis of the data have created a base of knowledge about the sexual and reproductive health of young men of color with notable biases and limitations.

This report has two main parts. It begins with a description of the sexual and reproductive health outcomes for young men of color—i.e., what society sees—followed by an analysis of the behaviors associated with these outcomes. The second part of the report presents challenges associated with understanding the sexual and reproductive health outcomes and behaviors of young men of color. These challenges include the data collection process itself (e.g., use of self-reports, sources of bias) as well as unmeasured influences on the sexual and reproductive health of young men of color.

[3] U.S. Census Bureau 2005.

[4] U.S. Census Bureau 2005.

[5] Leigh 2004a.

Outcomes

Pregnancy

Although historically pregnancy has been the major reproductive health outcome of concern for adolescents, the engagement of young men of color in teen pregnancies has dropped in recent years (Figures 1 and 2). Between 1995 and 2003, the proportion of young high school males of color who reported having impregnated a female decreased by around half among Hispanic, black non-Hispanic, and white non-Hispanic males. Despite these declines, black non-Hispanic male students remain the most likely to report having impregnated a female, followed by Hispanic male students, and finally white non-Hispanic male students.

In particular, in 1995, more than 12 percent of Hispanic high school males reported that they had impregnated someone; by 2003, only 5.2 percent reported the same—a halving of the 1995 rate (Figure 1). Most of this decline occurred between 1995 and 1997, however, when the rate dropped from 12.1 percent to 6.3 percent. In the six years between 1997 and 2003, the decline was only slight. The proportion of non-Hispanic black male high school students who had impregnated a female fell 44 percent between 1995 and 2003, from 13.5 percent to 7.6 percent of black male students. The rate dropped most rapidly between 1999 and 2003, decreasing from 12.7 percent in 1999 to 10.8 percent in 2001, and then to 7.6 percent in 2003. This same proportion among white non-Hispanic male high school students steadily decreased from 3.6 percent to 1.7 percent between 1995 and 2003—a 53 percent decrease (Figure 1).[6]

Sexually Transmitted Infections

Although chlamydia, gonorrhea, and syphilis, three of the most common sexually transmitted infections (STIs), are more prevalent among young black non-Hispanic males than among other young men, their peak rates occur among men of different ages. Among young men ages 15-29, chlamydia and gonorrhea rates were highest among males ages 20-24. Syphilis rates, however, were highest among males ages 25-29 in 2004, although they were highest among 20- to 24-year-old males in 1999.

Between 1999 and 2004, reported chlamydia rates among young men of color ages 15-29 increased—dramatically, in some cases. Although the gonorrhea rates of young black men significantly declined during this period (while rates among young men of other racial/ethnic groups either increased, remained steady, or showed minimal declines), their rates remained much higher than the rates among young men of other racial/ethnic groups. Syphilis rates of young black men significantly declined between 1999 and 2003, but then sharply increased between 2003 and 2004. Syphilis rates for other young men also increased between 2003 and 2004.[7]

Chlamydia

Between 1999 and 2004, chlamydia rates increased for all young men ages 15-29. Although peak rates were reported for males ages 20-24, the greatest rate increases during that period generally were reported among men ages 25-29 (Figures 3, 4, and 5). The reported chlamydia rate among American Indian/Alaska Native men ages 25-29 increased 98 percent between 1999 and 2004, nearly doubling from 334 cases per 100,000 to more than 659 cases per 100,000 (Figure 5). The rate among black men in that age group climbed 59 percent, from 1,009 cases per 100,000 to 1,605 cases per 100,000. The rate among Hispanic men ages 25-29 grew nearly as fast—more than 53 percent. The highest rate of increase among men ages 25-29, however, was among white non-Hispanic men; the rate more than doubled in five years from a cohort low of 87 cases per 100,000 in 1999 to nearly 189 per 100,000 in 2004.[8]

[6] Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.
[7] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[8] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

Reported chlamydia rates rose nearly as much among most men ages 20-24 between 1999 and 2004, although rates of increase were higher for Hispanic and Asian/Pacific Islander men ages 20-24 than for their 25- to 29-year-old counterparts (Figure 4). Among men ages 20-24, rates rose nearly 89 percent among American Indian/Alaska Native men (from 606 per 100,000 to 1,145 per 100,000), 73 percent among white non-Hispanic men (from 205 per 100,000 to 354 per 100,000), 52 percent among Hispanic men (from 450 per 100,000 to 685 per 100,000), 47 percent among Asian/Pacific Islander men (from 170 per 100,000 to 250 per 100,000), and 40 percent among black non-Hispanic men (from 1,949 per 100,000 to 2,731 per 100,000).[9]

Chlamydia rates rose least dramatically among young men ages 15-19 (Figure 3). Rates increased the most among black non-Hispanic adolescent males—more than 37 percent between 1999 and 2004 (from 1,369 per 100,000 to 1,881 per 100,000). The increases among American Indian/Alaska Native, white non-Hispanic, and Hispanic males ages 15-19 were comparable at 34 percent, 34 percent, and 32 percent, respectively. In contrast, rates actually declined by more than 11 percent among Asian/Pacific Islander males, from 126 per 100,000 to 111 per 100,000.[10]

Gonorrhea

Gonorrhea rates among young black non-Hispanic men have significantly fallen in the first part of the 21st century, whereas rates among males of other racial/ethnic groups have remained steady or increased slightly (Figures 6, 7, and 8). Between 1999 and 2004, the gonorrhea rate among black males ages 15-19 fell 29 percent (from 1,964.8 per 100,000 to 1,390.1 per 100,000). Among black males ages 20-24, the gonorrhea rate also declined by 32 percent (from 3,541.4 per 100,000 to 2,408.3 per 100,000). The gonorrhea rate decreased more than 17 percent among black males ages 25-29 (from 2,185.2 per 100,000 to 1,807.4 per 100,000).[11]

Despite these decreases, gonorrhea rates among young black men still remain much greater than the rates for males of other racial/ethnic groups (Figures 6, 7, and 8). In 2004, the gonorrhea rates among black males ages 15-19, 20-24, and 25-29 were 1,390.1 per 100,000, 2,408.3 per 100,000, and 1,807.4 per 100,000, respectively. By comparison, the respective rates among American Indian/Alaska Native males were 137.4 per 100,000, 304.6 per 100,000, and 185.4 per 100,000. The corresponding rates among Asian/Pacific Islander males were the lowest among all young males—26.2 per 100,000, 66.0 per 100,000, and 47.3 per 100,000, respectively.[12]

Syphilis

Syphilis rates among young black men significantly declined between 1999 and 2003, although rates increased between 2003 and 2004 (Figures 9, 10, and 11). Among young black men ages 15-19, the rate dropped by nearly 37 percent, from 9.3 cases per 100,000 to 5.9 cases per 100,000 population. Among men ages 20-24, the rate declined from 30.2 per 100,000 to 21.1 per 100,000 (a 30 percent decline), and among men ages 25-29, the rate decreased from 29.7 per 100,000 to 24.1 per 100,000 (a nearly 19 percent decrease). Between 2003 and 2004, however, rates for all three age cohorts increased significantly—24 percent among 15- to 19-year-olds, 21 percent among 20- to 24-year-olds, and 44 percent among 25- to 29-year-olds.[13]

Young black men continue to have significantly higher syphilis rates than young men of other racial/ethnic groups. Although the rates of syphilis among young Hispanic men increased between 1999 and 2004, the 2004 rates were less than a third of those of young black men (Figures 9, 10, and 11). Rates among American Indian/Alaska Native young men fluctuated greatly between 1999 and 2004. The rates among American Indian/Alaska Native men ages 25-29 during that period were 2.5 per 100,000 in 1999, 13.7 per 100,000 in 2001, 3.8 per 100,000 in 2002, and 6.3 per 100,000 in 2004 (Figure 11). Rates among Asian/Pacific Islander and white non-Hispanic men ages 20-24 and 25-29 steadily grew between 1999 and 2004 (Figures 10 and 11). The syphilis rate for Asian/Pacific Islander

[9] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[10] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[11] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[12] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[13] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

men ages 20-24 increased fourfold between 1999 and 2004, from 0.7 per 100,000 to 3.2 per 100,000. The rate for Asian/Pacific Islander men ages 25-29 tripled, from 1.4 per 100,000 to 4.5 per 100,000. For whites, the rate tripled among men ages 20-24 (from 0.8 per 100,000 to 2.9 per 100,000), and the rate quadrupled among men ages 25-29 (from 1.1 per 100,000 to 4.9 per 100,000).[14]

HIV Infection and AIDS

At the beginning of the epidemic in the early 1980s, HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome) were most prevalent among—and therefore associated with—young white non-Hispanic males. Today, young white men are underrepresented among reported cases of HIV infection and AIDS. American Indian/Alaska Native young men and Asian and Pacific Islander young men are similarly underrepresented, while young black non-Hispanic males are now overrepresented among reported cases of this disease. These young black men reported between nearly 40 percent and 60 percent of HIV cases in 2001 among men ages 13-19, 20-24, and 25-29, even though they represent less than 15 percent of the total male population in these age categories (Figures 12 and 13). The same pattern exists for AIDS cases, with young black males accounting for between 32 percent and 40 percent of AIDS cases reported for males in these age categories (Figure 14). Thus, although the affected racial/ethnic groups have changed, HIV infection continues to be more prevalent among young men than among men of other ages.

HIV infection and AIDS can result from sexual-risk behaviors among young men of color, as well as from other risky behaviors such as substance use. In 2001, although less than 15 percent of all males ages 13-19 were black non-Hispanic, these youth accounted for nearly three-fifths (59 percent) of all cases of HIV infection among males in this age group (Figures 12 and 13). The black non-Hispanic shares of HIV cases among HIV-positive males ages 20-24 and 25-29 were 46 percent and nearly 40 percent, respectively. These shares were still disproportionate to black males' representation among males in those age groups, however (nearly 13 percent of all males age 20-24 and nearly 12 percent of all males ages 25-29). These findings indicate that black teenage males are acquiring HIV infection at a higher rate than both their age peers of other racial/ethnic groups and slightly older black males.

Teenagers who engage in risky behaviors and contract HIV (as well as those who contracted HIV from their mothers but survived to adolescence) are likely to grow into adults infected with HIV and AIDS. Currently, disproportionate representation is most extreme among younger black males, with black male representation becoming less disproportionate in successive age cohorts. If these younger males age (rather than die) as time passes, however, the peak prevalence will shift to older age cohorts, translating into an increase in the proportions of older black males (i.e., 30 years and older) who are HIV-positive and who have AIDS. The development of anti-retroviral and other drug treatments for disease symptoms, which slow the progression of HIV infection, means that HIV-positive males will be able to live longer. In the future, black males may account for disproportionately high percentages of cases of HIV infection among men of all age categories. At the same time, if current infection rates continue, young black men also will continue to account for a disproportionate share of cases of HIV infection among young men.[15]

The same pattern (as with HIV infection) held for young black males diagnosed with AIDS in 2001. They accounted for 40 percent, 37 percent, and 32 percent of cases of AIDS among males ages 13-19, 20-24, and 25-29, respectively (Figure 14).[16] These percentages will likely increase for each age group in the future as the 13- to 19-year-olds with AIDS age and become part of the 20- to 24-year-old age cohort, the 20- to 24-year-olds become 25- to 29-year-olds, the 25- to 29-year-olds become 30- to 34-year-olds, and so on. As a result, black males are likely to represent disproportionately larger and larger shares of young men with AIDS.

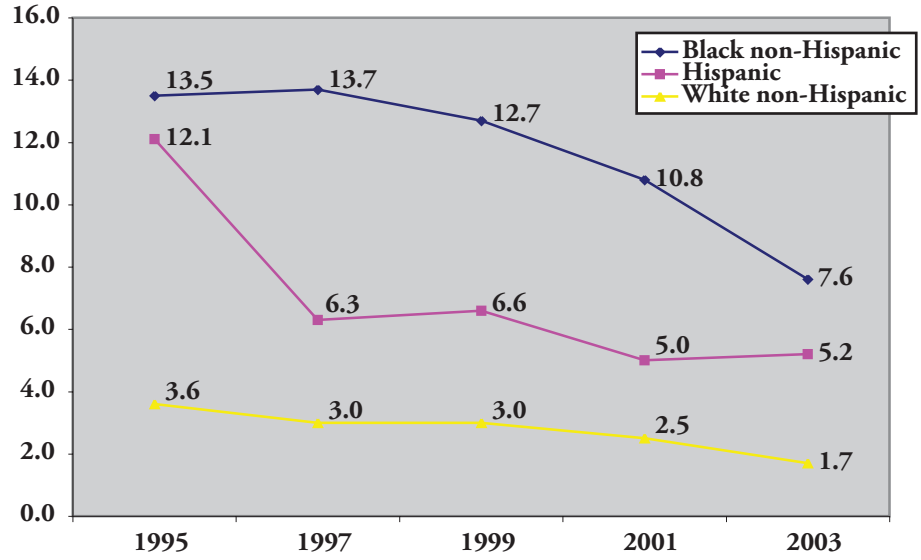
[14] Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.
[15] Centers for Disease Control and Prevention 2002.
[16] Centers for Disease Control and Prevention 2002.

Young males of all other racial/ethnic groups were underrepresented among HIV cases in 2001. Asian/Pacific Islander males accounted for one percent or fewer of the cases of HIV infection and AIDS among young men, despite making up 4.4 percent, 3.6 percent, and 6.0 percent of males ages 13-19, 20-24, and 25-29, respectively (Figures 12, 13, and 14). Although they were disproportionately overrepresented at the beginning of the AIDS outbreak in the early 1980s, young white males were underrepresented in HIV infection and AIDS cases in 2001. American Indian/Alaska Native males were slightly underrepresented among cases of HIV infection and AIDS, as well.[17]

In 2001, Hispanic males represented 8.8 percent of HIV-positive males ages 13-19, 10.2 percent of HIV-positive males ages 20-24, and 11.3 percent of HIV-positive males ages 25-29 (Figure 13). Since at that time Hispanic males accounted for 16.4 percent, 18.0 percent, and 18.1 percent of all males ages 13-19, 20-24, and 25-29, respectively, they were underrepresented among young HIV-positive males (Figure 12). Among AIDS cases in 2001, however, Hispanic males were slightly overrepresented, accounting for 22.3 percent, 22.0 percent, and 20.5 percent of the cases among males ages 13-19, 20-24, and 25-29, respectively (Figure 14).[18]

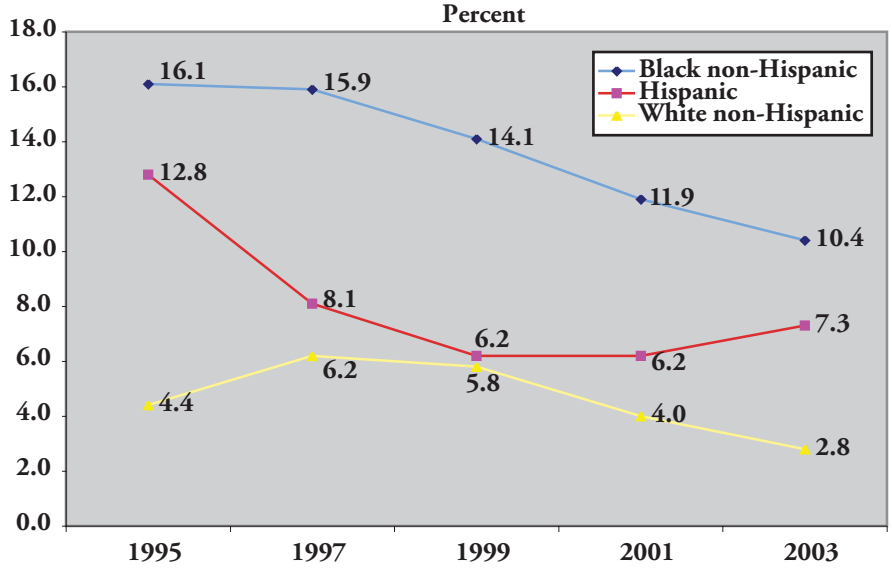
[17] U.S. Census Bureau 2001; and Centers for Disease Control and Prevention 2002.
[18] U.S. Census Bureau 2001; and Centers for Disease Control and Prevention 2002.

FIGURE 1
High school males who have impregnated someone, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



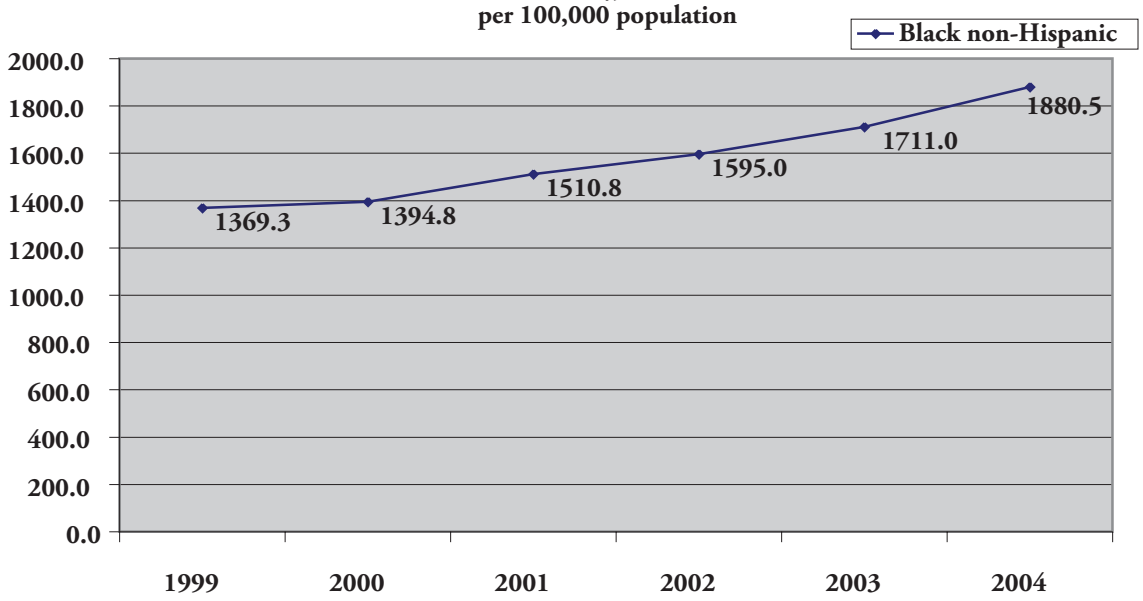
Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.

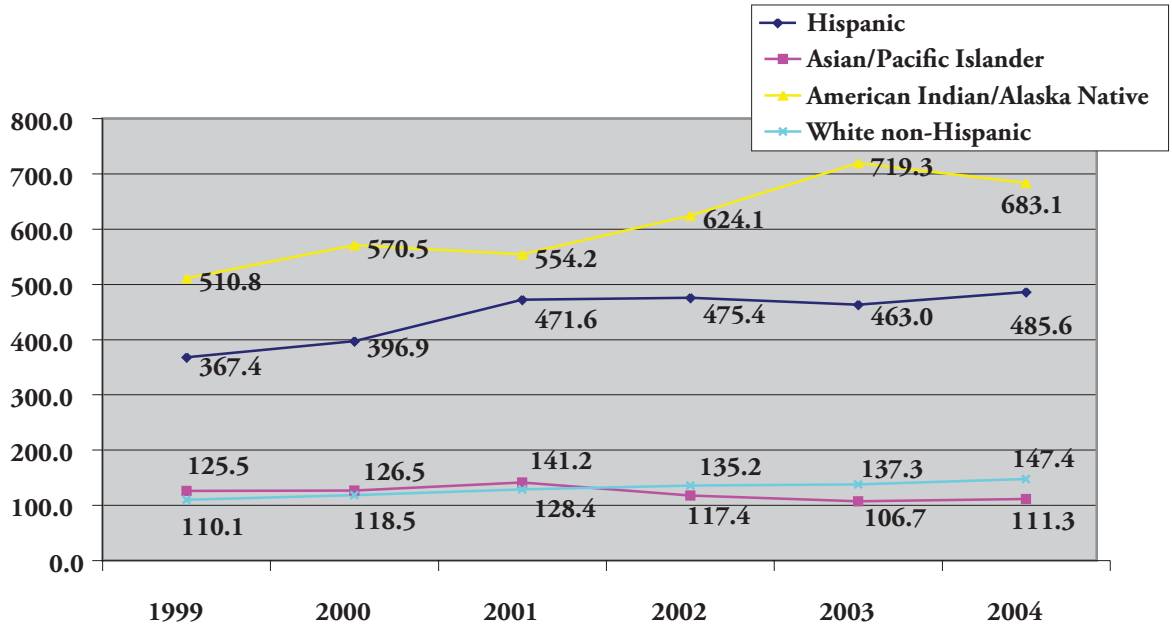
FIGURE 2
High school females who have been pregnant, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.

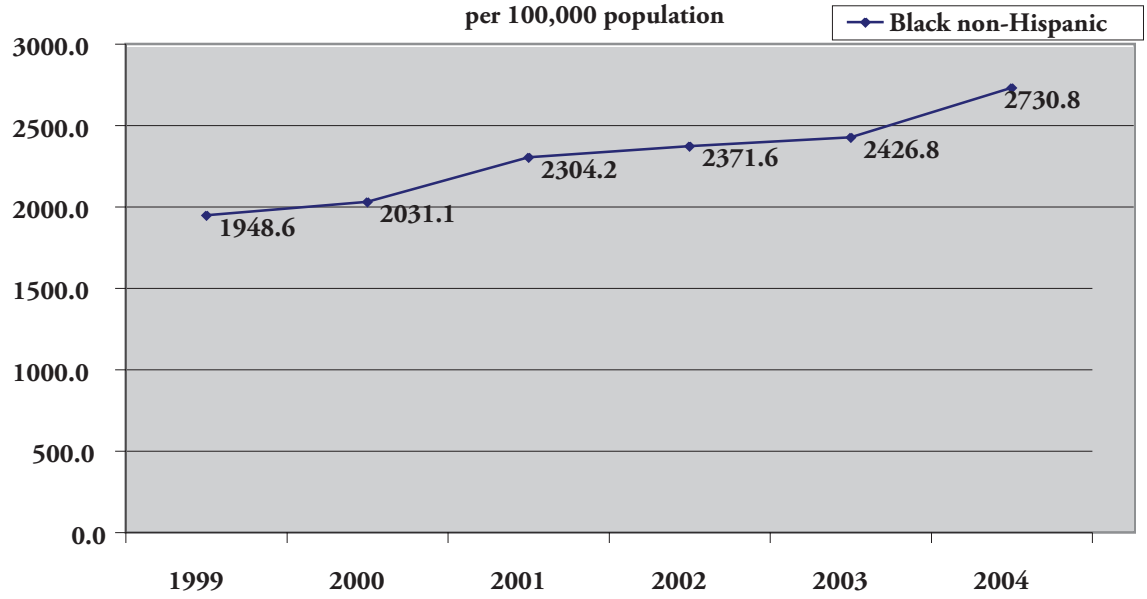
FIGURE 3
Chlamydia rates for males ages 15-19, by race/ethnicity, 1999-2004 per 100,000 population

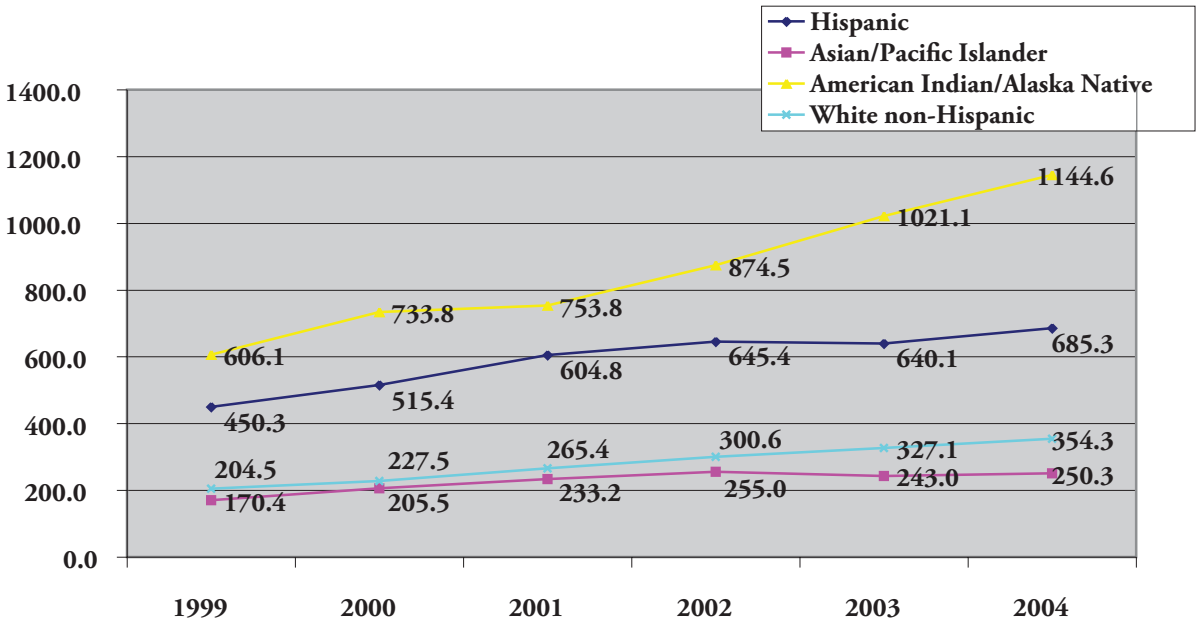




Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

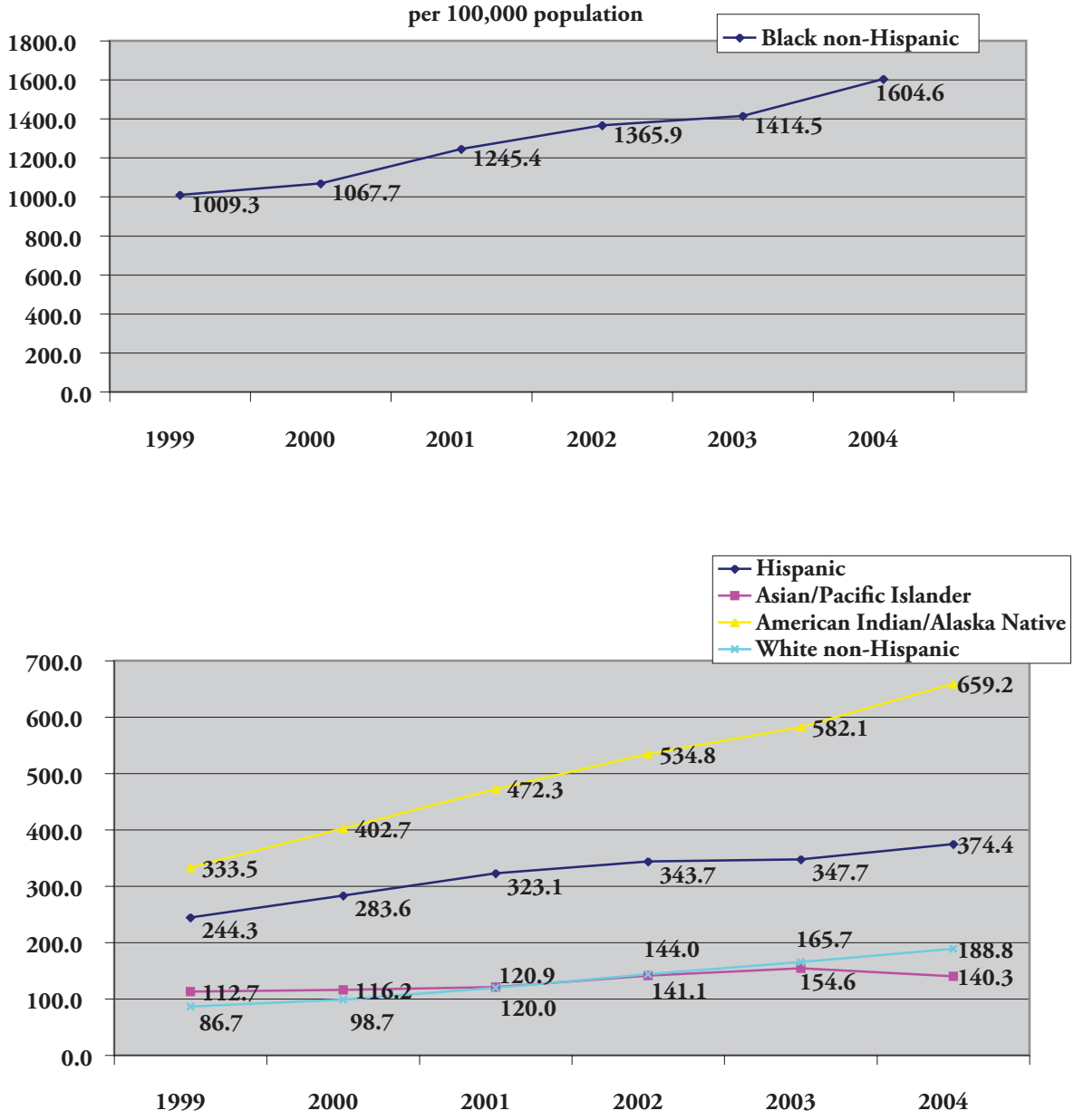
FIGURE 4
Chlamydia rates for males ages 20-24, by race/ethnicity, 1999-2004 per 100,000 population





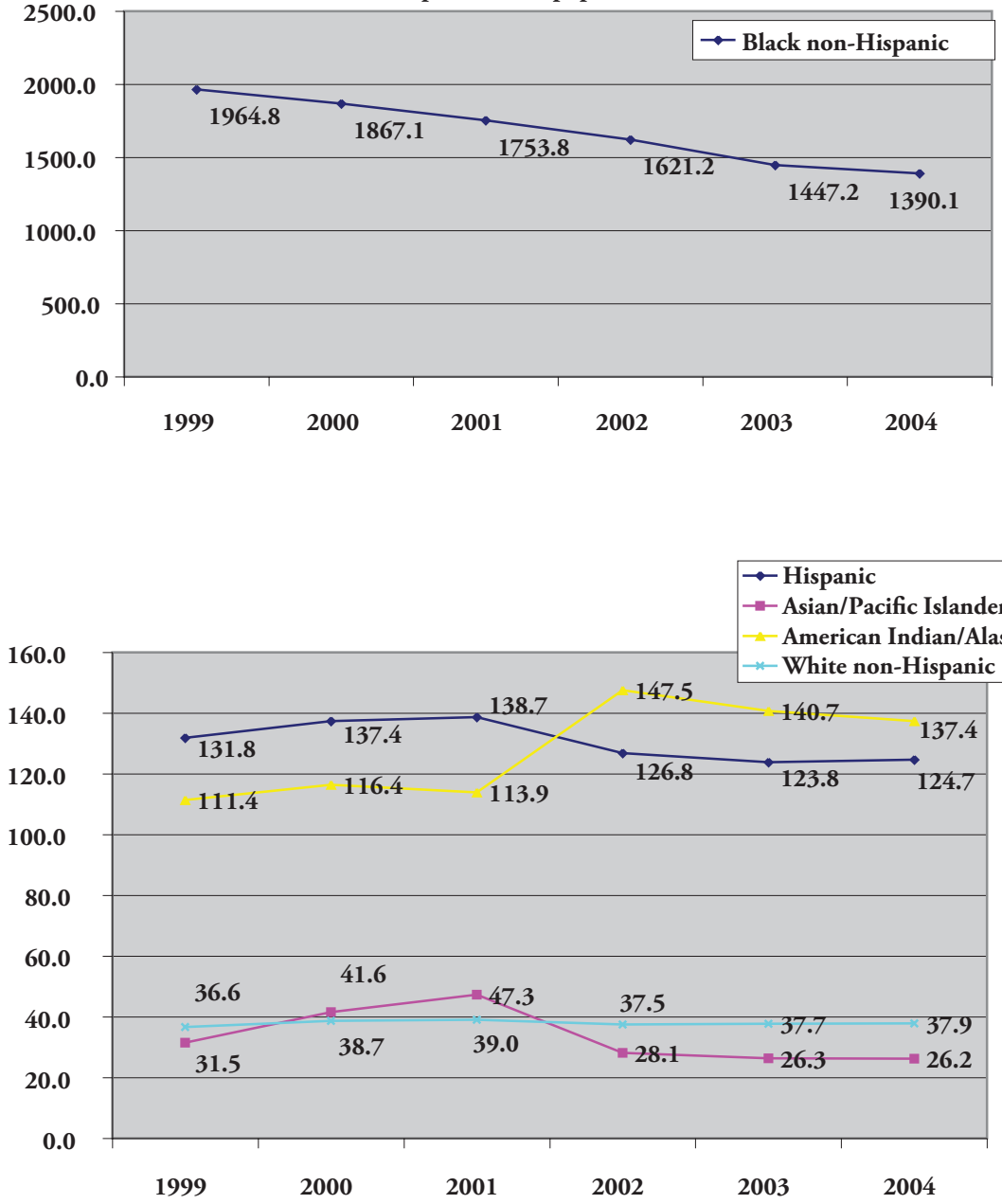
Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

FIGURE 5
Chlamydia rates for males ages 25-29, by race/ethnicity, 1999-2004 per 100,000 population



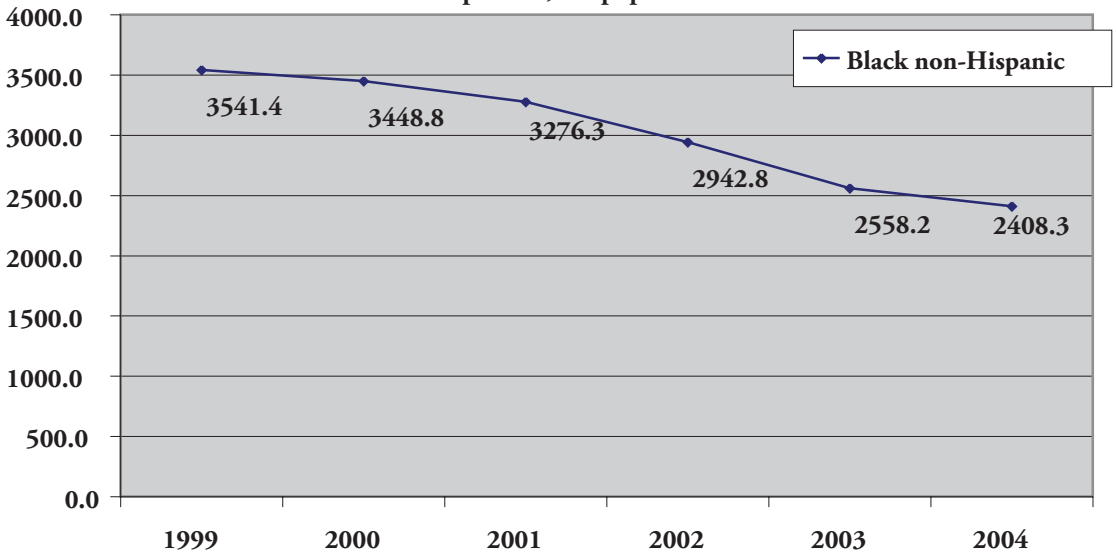
Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

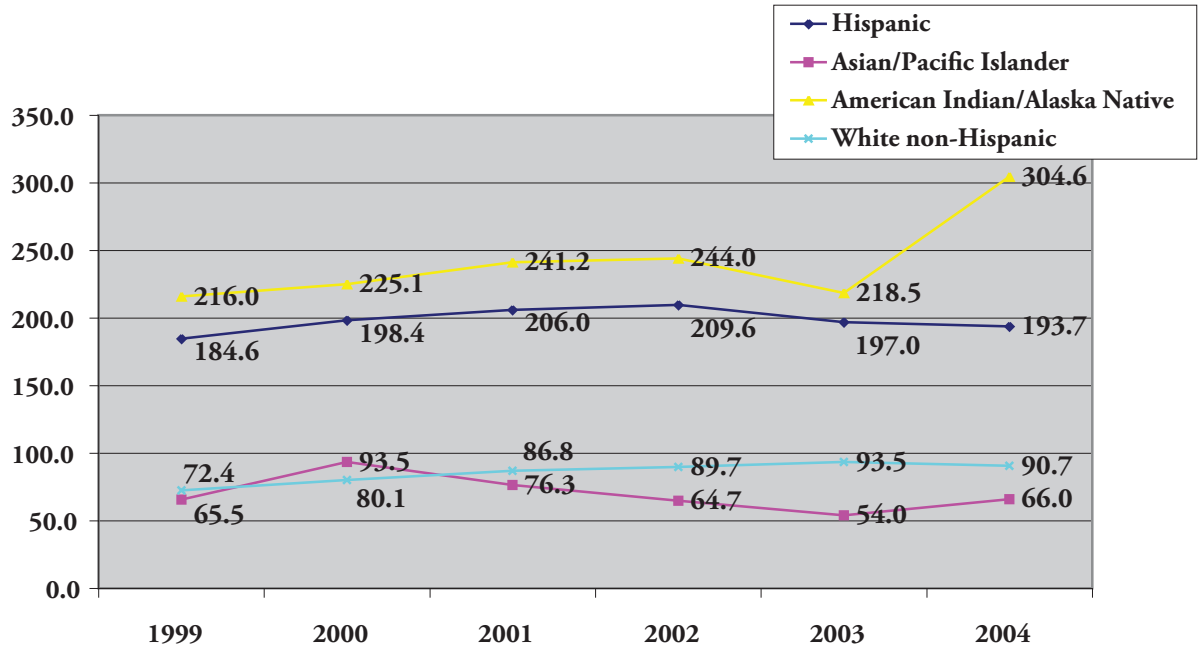
FIGURE 6
Gonorrhea rates for males ages 15-19, by race/ethnicity, 1999-2004 per 100,000 population



Sources: Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

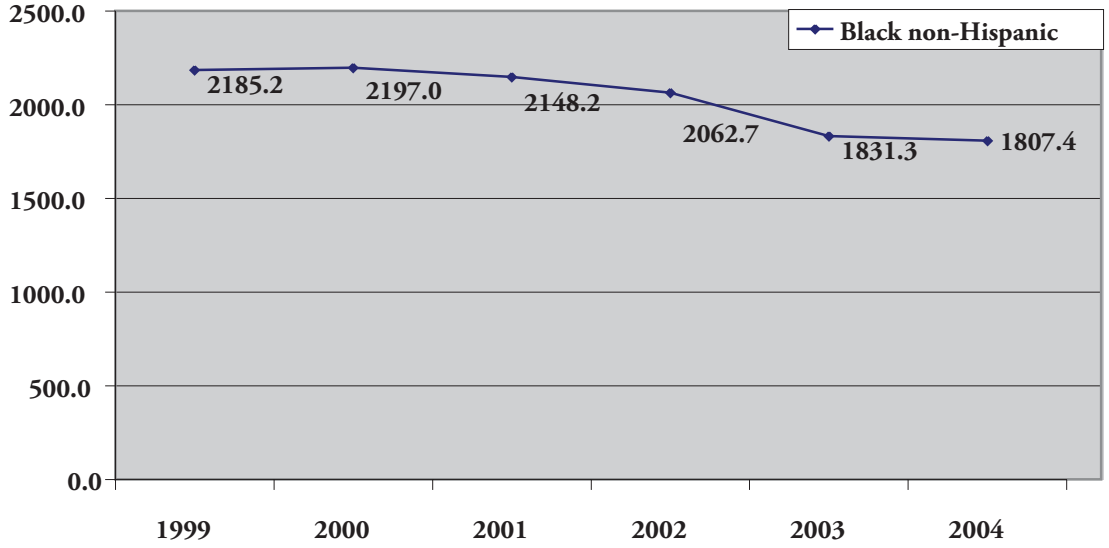
FIGURE 7
Gonorrhea rates for males ages 20-24, by race/ethnicity, 1999-2004
per 100,000 population

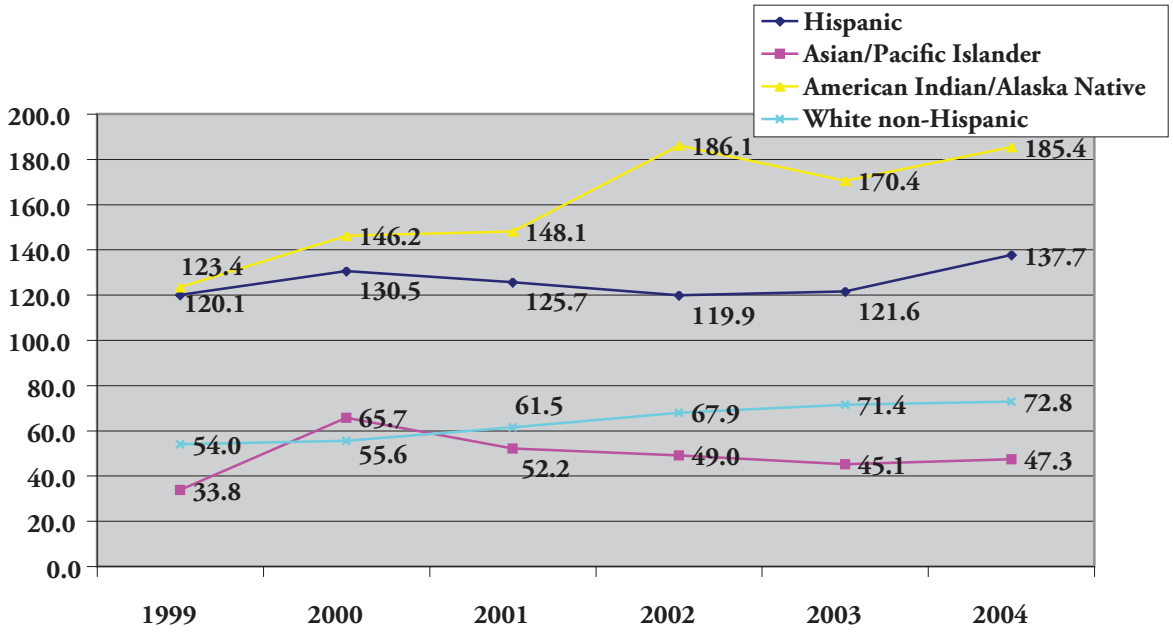




Sources: Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

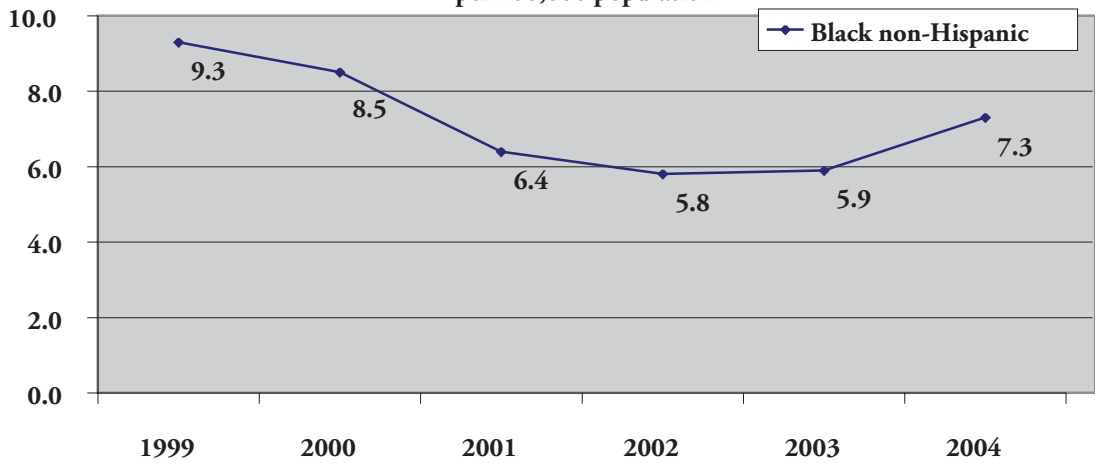
FIGURE 8
Gonorrhea rates for males ages 25-29, by race/ethnicity, 1999-2004 per 100,000 population

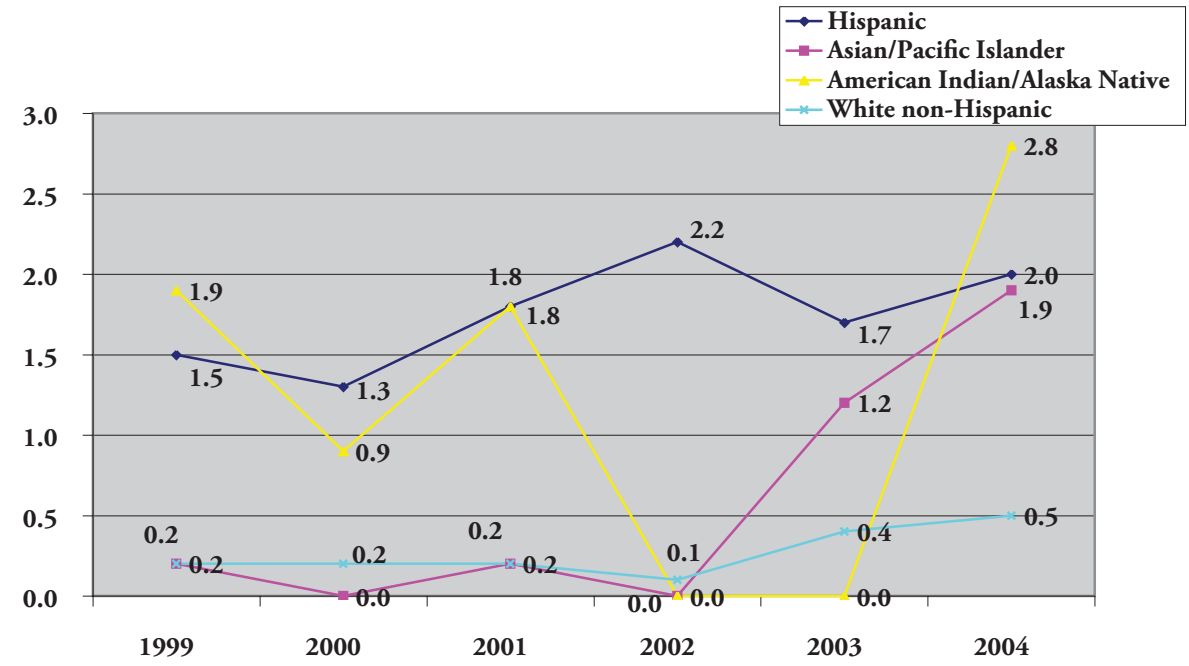




Sources: Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

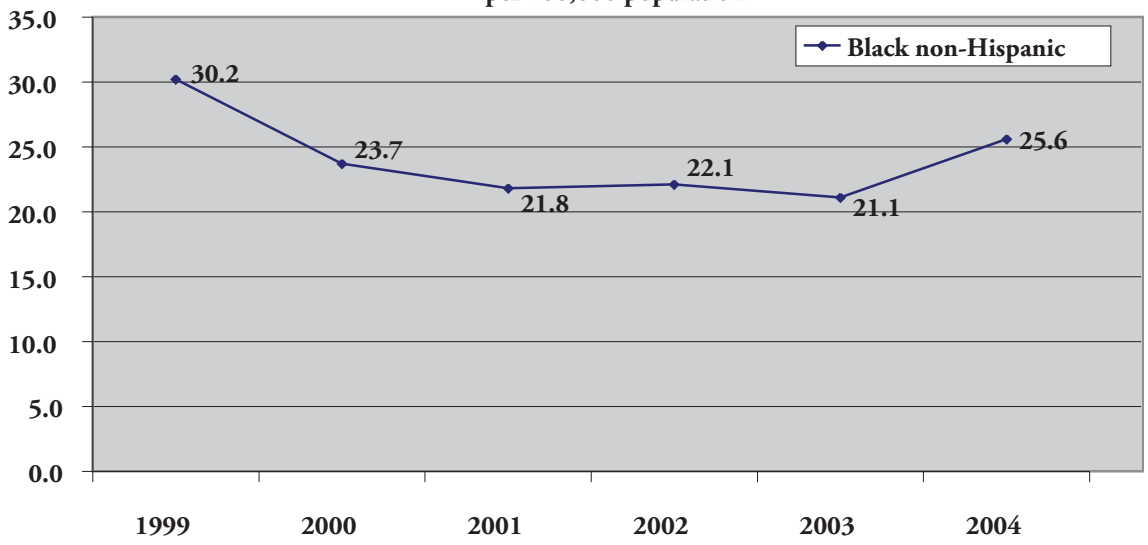
FIGURE 9
Syphilis rates for males ages 15-19, by race/ethnicity, 1999-2004
per 100,000 population

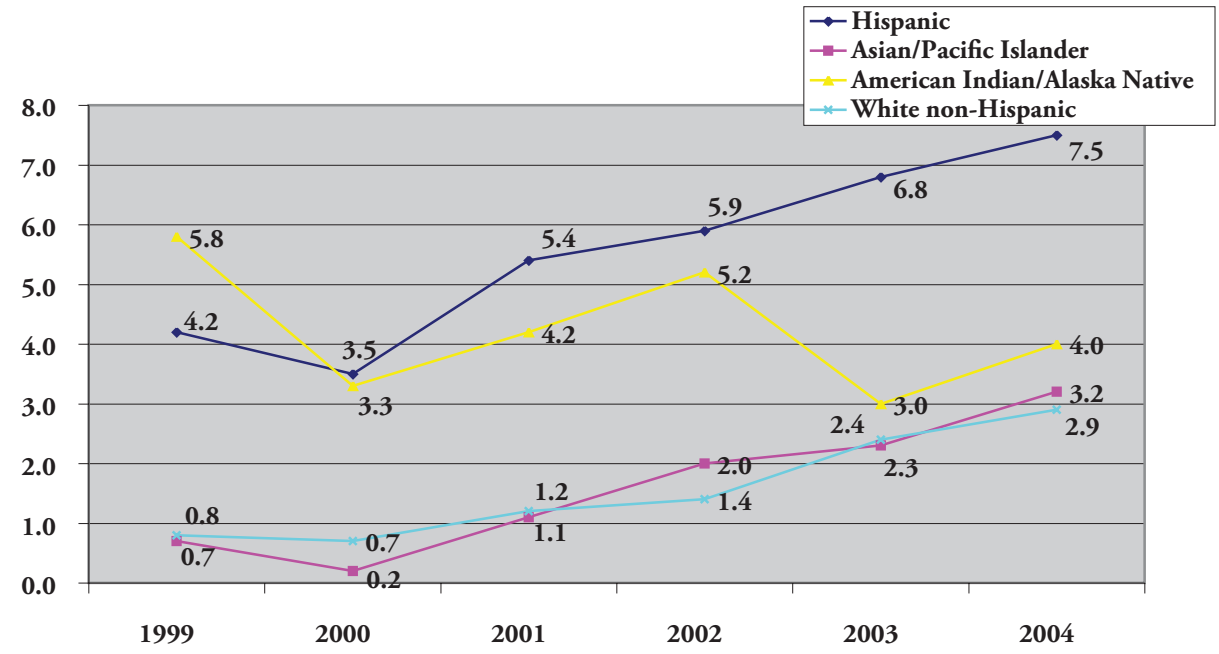




Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

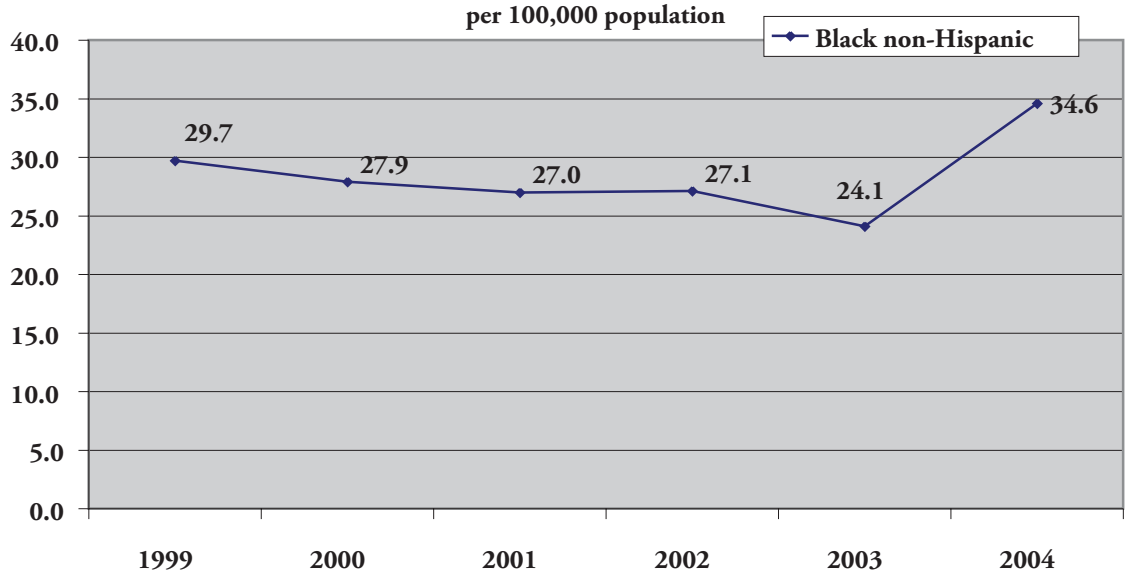
FIGURE 10
Syphilis rates for males ages 20-24, by race/ethnicity, 1999-2004
per 100,000 population

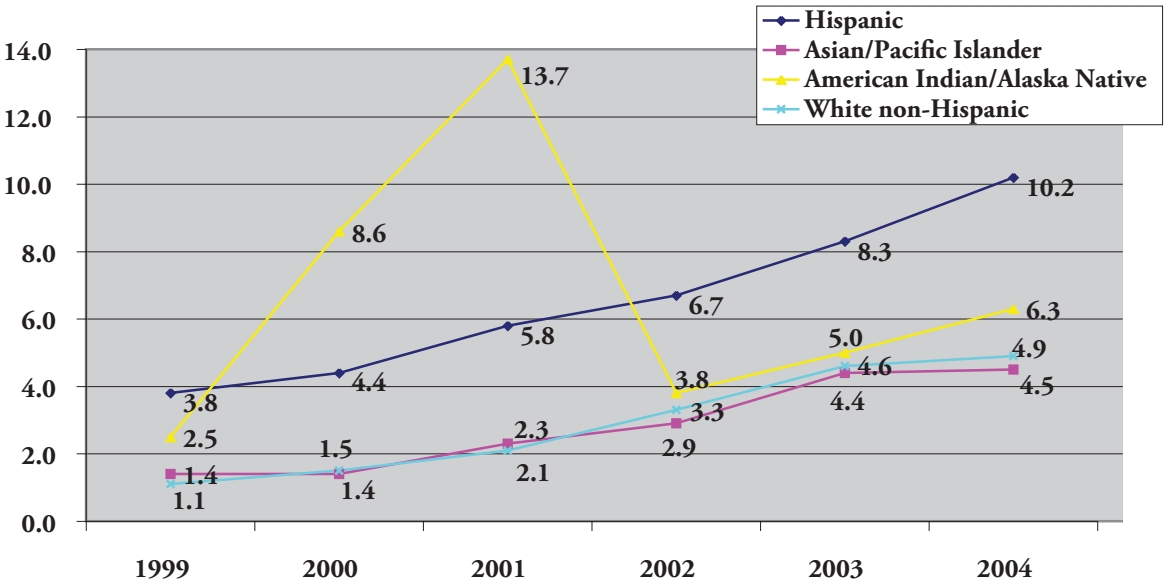




Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

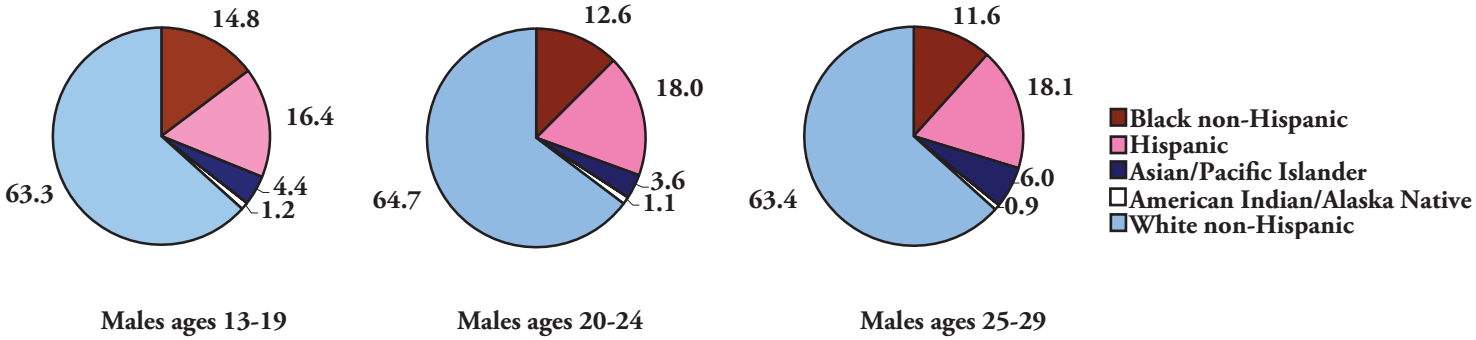
FIGURE 11
Syphilis rates for males ages 25-29, by race/ethnicity, 1999-2004
per 100,000 population





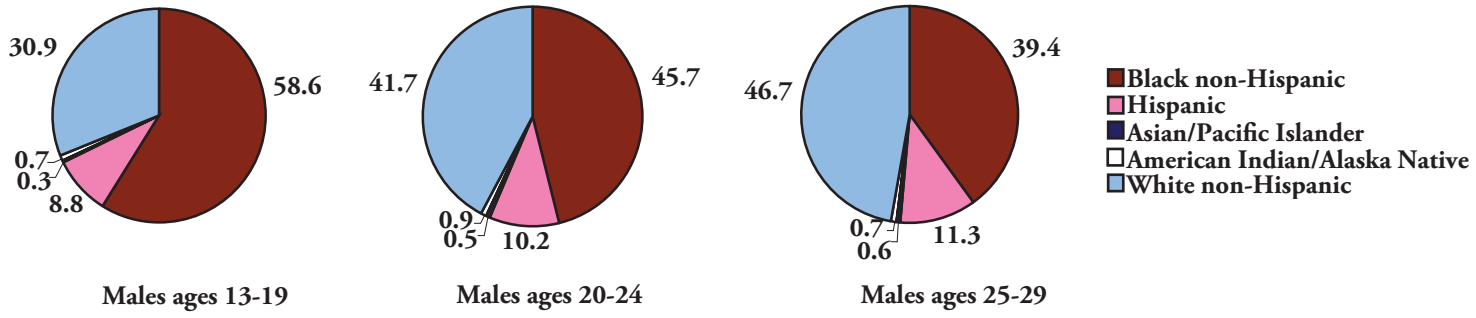
Sources : Centers for Disease Control and Prevention 2004; and Centers for Disease Control and Prevention 2005.

FIGURE 12
Age distribution of males, by race/ethnicity, 2001
Percent



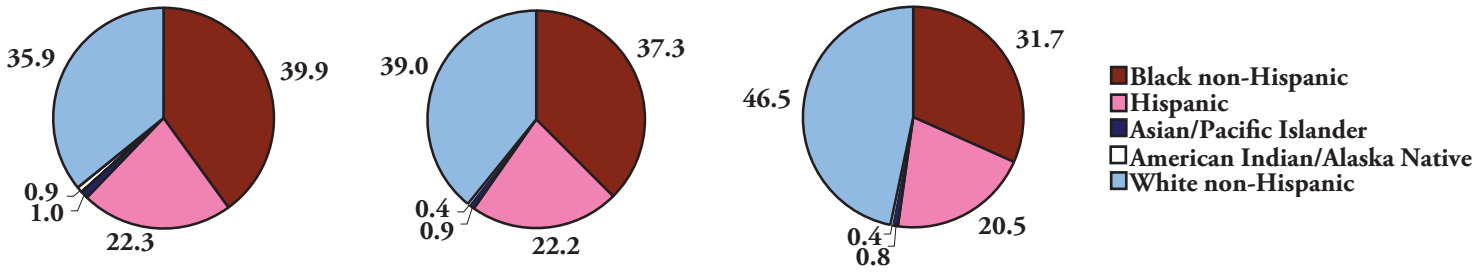
Source: U.S. Census Bureau 2001.

FIGURE 13
Distribution of HIV cases among males, by race/ethnicity, 2001
Percent



Source: Centers for Disease Control and Prevention 2002.

FIGURE 14
Distribution of AIDS cases among males, by race/ethnicity, 2001
Percent



Source: Centers for Disease Control and Prevention 2002.

Behaviors

The sexual and reproductive health outcomes among young adolescent men of color frequently result from the often risky behaviors in which these young men engage. These behaviors—for example, having sexual intercourse, initiating sexual activity early, having multiple sexual partners, engaging in unprotected sexual activity, and using alcohol or drugs before sexual activity—are risky because they make young men more vulnerable to contracting or spreading an STI (such as chlamydia, gonorrhea, syphilis, or HIV) and more likely to impregnate a female. Although exceptions exist, over the past decade, young men of color have decreased their participation in risky sexual behaviors and have taken steps to protect themselves against the possible consequences of their actions. For example, they are now more likely to use condoms and other contraceptives, less likely to have multiple partners, and more likely to delay initiation of sexual activity.

Experience with Sexual Intercourse

One prominent example of the overall reduction in sexual-risk behaviors is the decline since the early 1990s in the proportion of high school males who report having had sexual intercourse.[19] Between 1993 and 2003, the proportion of black non-Hispanic male students who had ever had sexual intercourse decreased from 89 percent to 74 percent (Figure 15). The proportion of Hispanic male students decreased from nearly 64 percent to 57 percent, and the proportion of white male students declined from more than 49 percent to nearly 41 percent.[20] Despite the declining rate, black non-Hispanic male students remained far more likely than their Hispanic or white non-Hispanic peers to have had sexual intercourse. American Indian male high school students, however, were nearly as likely as black non-Hispanic male students to have had sexual intercourse (Figure 15). In 2001, nearly 66 percent of American Indian male students reported having had sexual intercourse, compared to nearly 69 percent of black male students. This 66 percent rate is a modest decrease from 1997, when 71 percent of American Indian male students reported that they had had sexual intercourse.[21]

If young males do not engage in sexual intercourse, they are less likely to be infected with HIV or STIs such as chlamydia, or to impregnate a female. As they age, however, adolescent males become more likely to engage in sexual behaviors. In 2002, young men ages 18-19 were twice as likely as males ages 15-17 to have had sexual intercourse—nearly 65 percent versus nearly 32 percent (Figure 16). Among both age cohorts, black non-Hispanic males were the most likely to have had sexual intercourse, followed by Hispanic and white non-Hispanic males, respectively. More than 79 percent of black males ages 18-19 had had sexual intercourse, compared with nearly 53 percent of black males ages 15-17.[22] Nearly 70 percent of 18- to 19-year-old Hispanic males had engaged in sexual intercourse, compared with nearly 43 percent of their younger peers. The greatest difference among age cohorts of one racial/ethnic group existed for white non-Hispanic males; although only 25 percent of white non-Hispanic males ages 15-17 had ever had sexual intercourse, 62 percent of their 18- to 19-year-old counterparts had.

Although in 2001 a majority of black non-Hispanic, American Indian, and Hispanic high school males reported having ever had sexual intercourse, smaller proportions reported being currently sexually active, which is defined as having had sexual intercourse in the three months preceding the survey (Figure 17). About half (52 percent) of black non-Hispanic male high school students reported being currently sexually active, compared with nearly 44 percent of American Indian, more than 37 percent of Hispanic, and 30 percent of white non-Hispanic male students.[23]

[19] In this report, unless otherwise specified, sexual intercourse refers to vaginal intercourse.
[20] Grunbaum et al. 2004; and Kann et al. 1995.
[21] Bureau of Indian Affairs 1997; Grunbaum et al. 2002; Kann et al. 1998; and Shaughnessy, Branum, and Everett-Jones 2001.
[22] Abma et al. 2004.
[23] Grunbaum et al. 2002.

Age at Sexual Debut

Black non-Hispanic high school males were more likely than Hispanic or white high school males to report having had sexual intercourse before age 13 (Figure 18). In 2001, 26 percent of black male students reported having had sexual intercourse before age 13, compared with 17 percent of American Indian male students and more than 11 percent of Hispanic male students. More than six percent of white non-Hispanic male students reported having sexual intercourse before age 13, a fourth of the rate reported by black male students.[24]

Early sexual initiation is sometimes associated with a history of sexual abuse. Adolescent males who were sexually abused are significantly more likely than their peers who were not to engage in sexual intercourse at an early age.[25] The proportions of males who had mixed feelings about making their sexual debut or did not want to make their sexual debut as teens suggest that for some young men of color, early sexual initiation may be involuntary (Figure 19). Black non-Hispanic males ages 18-24 were the most likely to report that they had not wanted their first sexual intercourse to happen at the time—9.4 percent, compared with 5.0 percent of white males and 3.7 percent of Hispanic males. Approximately one-third of young men (nearly 35 percent of black non-Hispanic, more than 33 percent of Hispanic, and 31 percent of white non-Hispanic men) reported having mixed feelings about making their sexual debut as teens.[26]

In stark contrast, the majority of young females who first had sexual intercourse before the age of 20 reported that they had mixed feelings or did not want to have intercourse at that time (Figure 20). Nearly 74 percent of Hispanic females, more than 73 percent of black non-Hispanic females, and nearly 62 percent of white non-Hispanic females reported mixed or negative feelings. Correspondingly, Hispanic and black non-Hispanic females were less likely than white non-Hispanic females to report that they wanted their first intercourse to happen when it did—more than 38 percent of white females, compared with 27 percent of black non-Hispanic and 26 percent of Hispanic females.[27]

Number of Sexual Partners

Age of sexual initiation appears to relate to the number of partners that a male high school student reports having had. Male students who initiate sexual activity at a younger age are more likely than those who initiate sexual activity at an older age to report more than four sexual partners. In 2001, black male high school students, the subgroup most likely to report sexual intercourse before age 13, also were the most likely to report having had four or more sexual partners during their lifetimes (nearly 39 percent), as indicated in Figures 18 and 21. American Indian male students, the male population second most likely to report having had intercourse before age 13, also were second most likely to report four or more partners (33 percent). Hispanic male students and white non-Hispanic male students, the groups least likely to have had first sexual intercourse before age 13, were also the least likely to have had four or more sexual partners (nearly 21 percent and nearly 13 percent, respectively).[28]

The frequency of reporting four or more sexual partners, however, did decline for high school male students of color in the years preceding 2001 (Figure 21). Between 1993 and 2001, the percentage of black non-Hispanic male high school students who reported having had four or more sexual partners decreased from nearly 59 percent to nearly 39 percent. In 2003, although this percentage increased to nearly 42 percent, it was still 29 percent below the 1993 level. The decline was less dramatic, although still noteworthy, among Hispanic males (from 26 percent to nearly 21 percent between 1993 and 2003) and white non-Hispanic males (from 15 percent to nearly 12 percent between 1993 and 2003).[29]

[24] Grunbaum et al. 2002; and Shaughnessy, Branum, and Everett-Jones 2001.
[25] Raj, Silverman, and Amaro 2000.
[26] Abma et al. 2004.
[27] Abma et al. 2004.
[28] Grunbaum et al. 2002; and Shaughnessy, Branum, and Everett-Jones 2001.
[29] Grunbaum et al. 2002; Grunbaum et al. 2004; Kann et al. 1995; Kann et al. 1996; Kann et al. 1998; and Kann et al. 2000.

The number of reported sexual partners also is positively associated with the number of years that men remain unmarried after their first sexual intercourse. Married men are more likely to have only one sexual partner and therefore also more likely to have a decreased risk of contracting an STI or HIV/AIDS. The years between sexual debut and marriage, however, may include a wide range of sexual activity, including having multiple partners. Black males experience more years of sexual activity as unmarried men than do males of other racial/ethnic groups—a trend that suggests a possible explanation for their higher rates of these infections. The median age at first intercourse for black male high school students is 13.6 years, while the median age at first marriage for black males is 25.0 years. This translates into potentially 11.4 years of sexual activity for black men before marriage. Asian males, whose median age at first intercourse is 18.1 years and whose median age at first marriage is 27.1 years, could experience 9.0 years of unmarried sexual activity. Hispanic men potentially could have 8.2 years of unmarried sexual activity (between the median ages of 15.9 and 24.1), while white men could have 7.1 years of unmarried sexual activity (between the median ages of 16.7 and 23.8).[30]

Use of Contraceptives

Contraceptive use generally is related to the outcomes of the sexual behaviors and behavioral patterns noted thus far. A 2002 survey of never-married young men ages 15-24 found that the condom is their preferred contraceptive, with the vast majority reporting condom use at least some of the time during sexual intercourse (Figure 22). Although young black non-Hispanic men reported the highest rates of STIs, this group was far more likely than young Hispanic and young white non-Hispanic men to report condom use—49 percent reported using condoms every time they had sexual intercourse, and nearly 46 percent reported using condoms some of the time. Only 5.3 percent reported never using condoms during sexual intercourse. More than 37 percent of Hispanic young men reported using condoms every time, nearly 47 percent reported using condoms some of the time, and nearly 16 percent reported never using condoms during sexual intercourse. One-third (33 percent) of white non-Hispanic young men reported using condoms every time, nearly 51 percent reported using condoms some of the time, and more than 16 percent reported never using condoms.[31]

Although a majority of never-married young men ages 15-24 do not use condoms every time that they have sexual intercourse, two-thirds or more of never-married young men ages 15-19 reported that they used condoms during their first sexual intercourse (Figures 22 and 23). More than 85 percent of black non-Hispanic males reported condom use at first intercourse, as did nearly 69 percent of white non-Hispanic young men and nearly 67 percent of Hispanic young men. Other methods of contraception used by never-married young men and their partners during first intercourse include birth control pills (alone or in conjunction with condoms) and withdrawal. More than 27 percent of young Hispanic men, however, reported using no contraceptive during their first sexual intercourse. Much smaller proportions of black non-Hispanic (nearly 14 percent) and white non-Hispanic (nearly 15 percent) males reported using no contraceptive during their first sexual intercourse (Figure 23).[32]

In addition, a majority of male high school students who are currently sexually active reported recent condom use. In 2001, nearly 73 percent of sexually active black non-Hispanic male high school students reported having used a condom during their last sexual intercourse (Figure 24). Nearly two-thirds of sexually active American Indian male students (nearly 65 percent) and white non-Hispanic male students (nearly 64 percent) also reported having used condoms. Sexually active Hispanic male high school students were the least likely to have used condoms during their last sexual intercourse (59 percent).[33]

[30] Kreider 2005; Upchurch et al. 1998; and Warren et al. 1998.
[31] Abma et al. 2004.
[32] Abma et al. 2004.
[33] Grunbaum et al. 2002; and Shaughnessy, Branum, and Everett-Jones 2001.

Alcohol or Drug Use during Sexual Intercourse

Many young men use alcohol or drugs while engaging in sexual activity. Alcohol or drug use during sexual activity hinders the user's ability to exercise good judgment about risky activities such as having multiple sexual partners and not using contraceptives.[34] The proportion of male high school students who reported using alcohol or drugs at the time of their last sexual intercourse did not display a consistent trend in the years surveyed between 1995 and 2003 (Figure 25). The proportions variously increased and decreased from year to year. In most years, white non-Hispanic male students were the most likely to report alcohol or drug use at the time of intercourse, with 36 percent reporting use in 1995 and 31 percent reporting use in 2003. Hispanic male students were usually next in reported likelihood of using drugs or alcohol with sexual activity—nearly 28 percent in 1995 and 30 percent in 2003. In all years, black non-Hispanic male students were the least likely to have used drugs or alcohol, although approximately one-quarter did so—27 percent in 1995 and 24 percent in 2003.[35]

Other Types of Sexual Intimacy

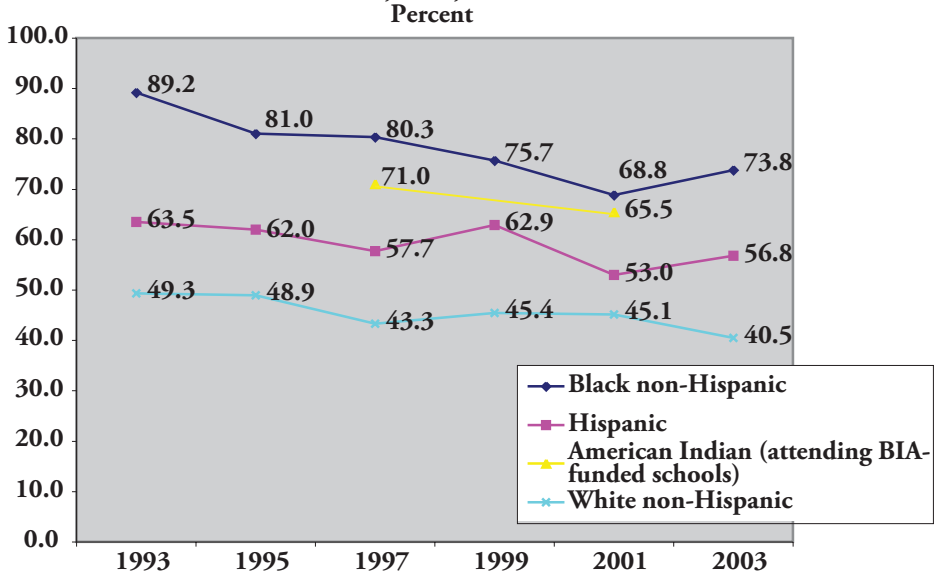
In addition to (or instead of) vaginal intercourse, young men often engage in other types of sexual activity with females, such as oral sex and anal sex (Figures 26 and 27). Two-thirds (nearly 67 percent) of Hispanic or Latino males ages 15-24 reported in 2002 that they had participated in oral sex (gave or received) with a female partner. This is a weighted average of nearly 53 percent of Hispanic or Latino males ages 15-19 and nearly 78 percent of Hispanic or Latino men ages 20-24. Nearly 69 percent of black non-Hispanic males ages 15-24 also reported having had oral sex with a female partner. This includes nearly 59 percent of black 15- to 19-year-olds and nearly 80 percent of black 20- to 24-year-olds. White non-Hispanic males were the most likely to have given or received oral sex—nearly 71 percent of all 15- to 24-year-olds. More than 85 percent of white 20- to 24-year-old males and 57 percent of white 15- to 19-year-old males reported in 2002 that they had ever given or received oral sex.[36]

Hispanic males ages 15-24 were the most likely to have had anal sex with a female (Figure 26). In 2002, more than 28 percent of Hispanic males ages 15-24 reported having had anal sex, compared with nearly 25 percent of black non-Hispanic and nearly 20 percent of white non-Hispanic males ages 15-24.[37]

Small percentages of young men of color reported same-sex sexual contact (Figure 28). Among males ages 15-24, between about five percent and six percent reported oral or anal sex with a male. Within this age cohort, older white non-Hispanic and black non-Hispanic males (ages 20-24) were more likely than their younger counterparts (ages 15-19) to report oral or anal sex with a male. Hispanic males ages 15-19 were more likely than their 20- to 24-year-old counterparts to report having had oral or anal sex with a male, however.[38]

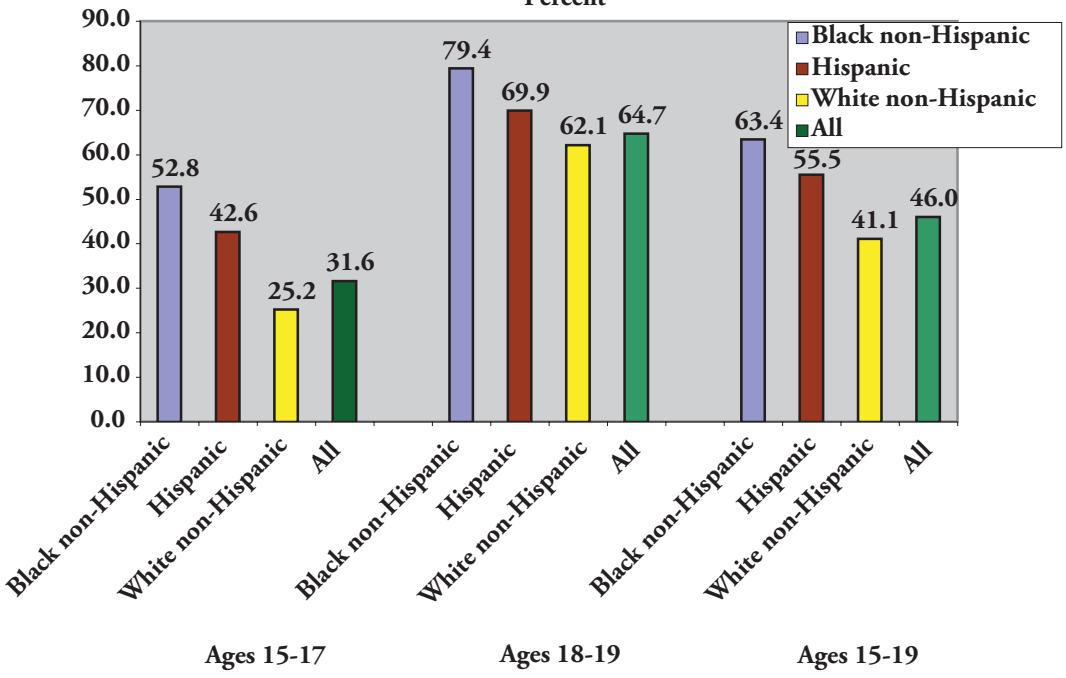
[34] Leigh and Stall 1993.
[35] Grunbaum et al. 2002; Grunbaum et al. 2004; Kann et al. 1996; Kann et al. 1998; and Kann et al. 2000.
[36] Mosher, Chandra, and Jones 2005.
[37] Mosher, Chandra, and Jones 2005.
[38] Mosher, Chandra, and Jones 2005.

FIGURE 15
High school males who have ever had sexual intercourse, by race/ethnicity, 1993, 1995, 1997, 1999, 2001, and 2003
Percent



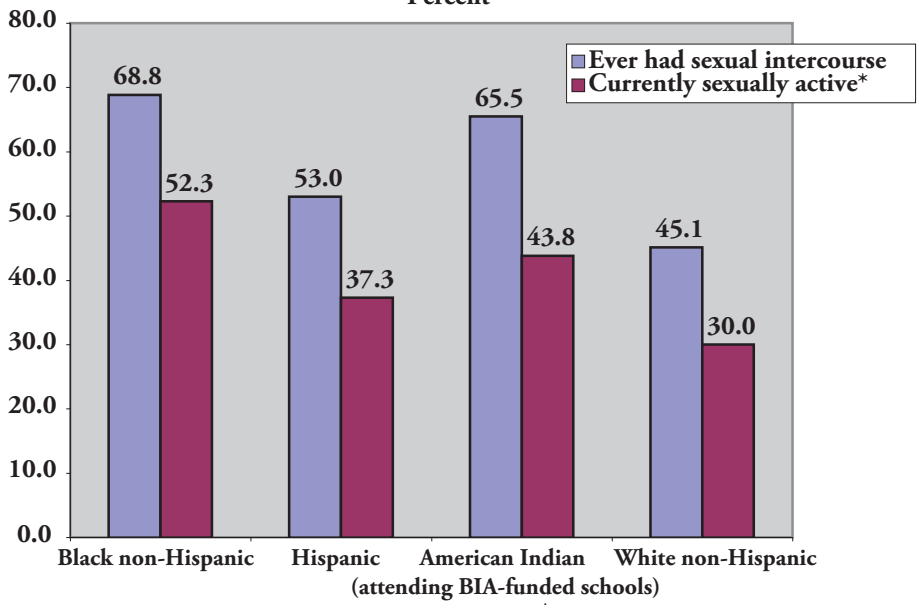
Sources: Kann et al. 1995; Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; Grunbaum et al. 2004; Bureau of Indian Affairs 1997; and Shaughnessy, Branum, and Everett-Jones 2001.

FIGURE 16
Males who have ever had sexual intercourse, by age and race/ethnicity, 2002
Percent



Source: Abma et al. 2004.

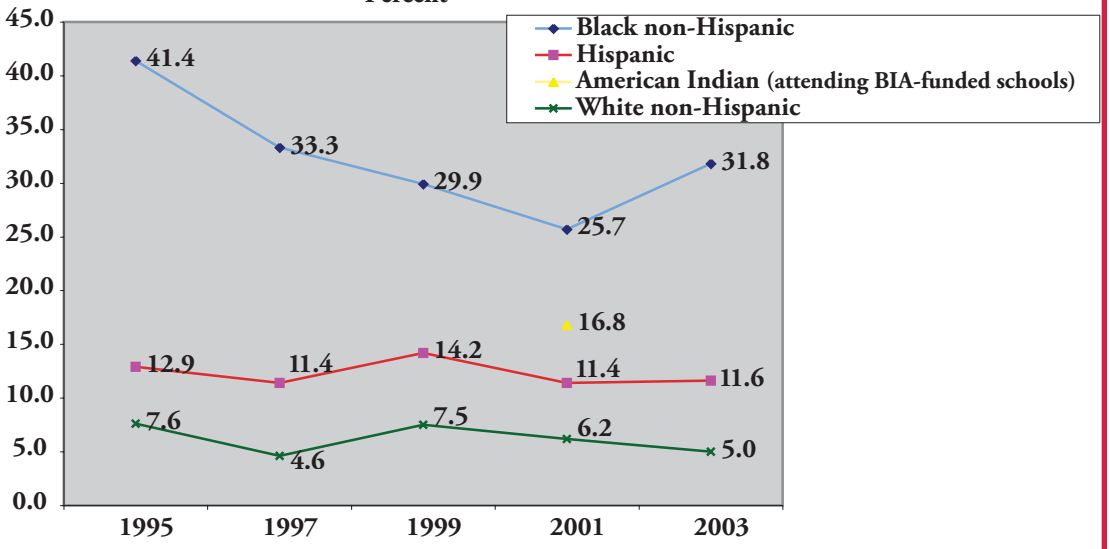
FIGURE 17
Reported sexual activity of high school males, by race/ethnicity, 2001
Percent



* Sexual intercourse during the three months preceding the survey.

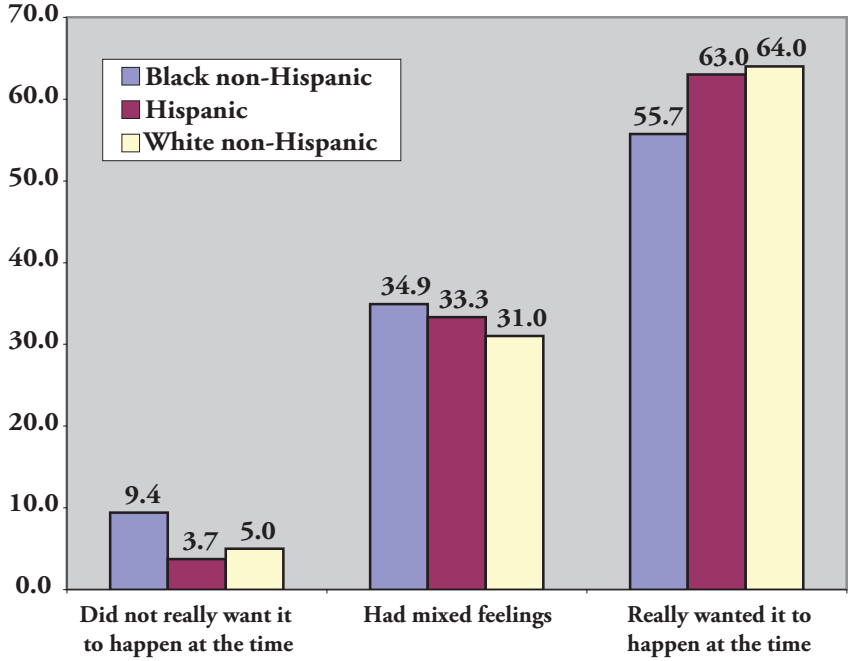
Sources: Grunbaum et al. 2002; and Shaughnessy, Branum, and Everett-Jones 2001.

FIGURE 18
Age at sexual initiation among high school males: had first sexual intercourse before age 13, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



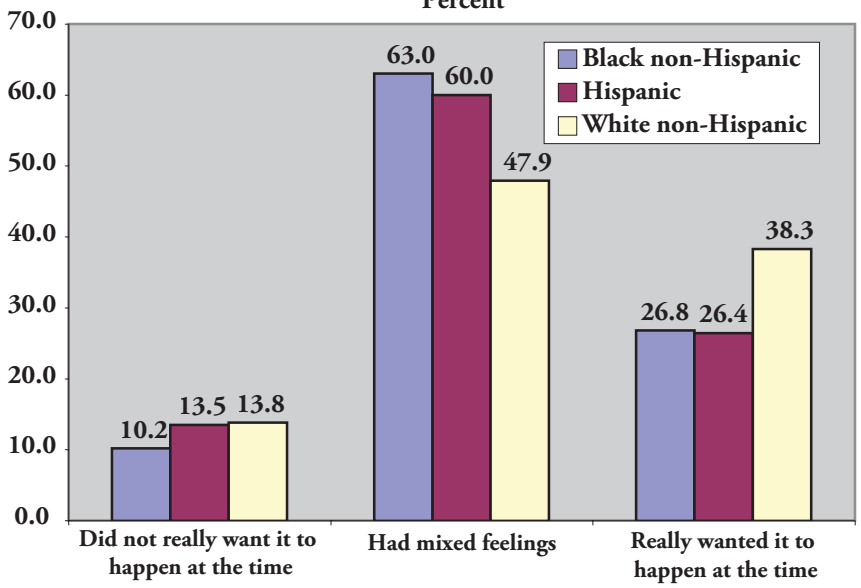
Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; Grunbaum et al. 2004; and Shaughnessy, Branum, and Everett-Jones 2001.

FIGURE 19
Distribution of males ages 18-24 who had sex before age 20, by how much first intercourse was wanted, by race/ethnicity, 2002
Percent



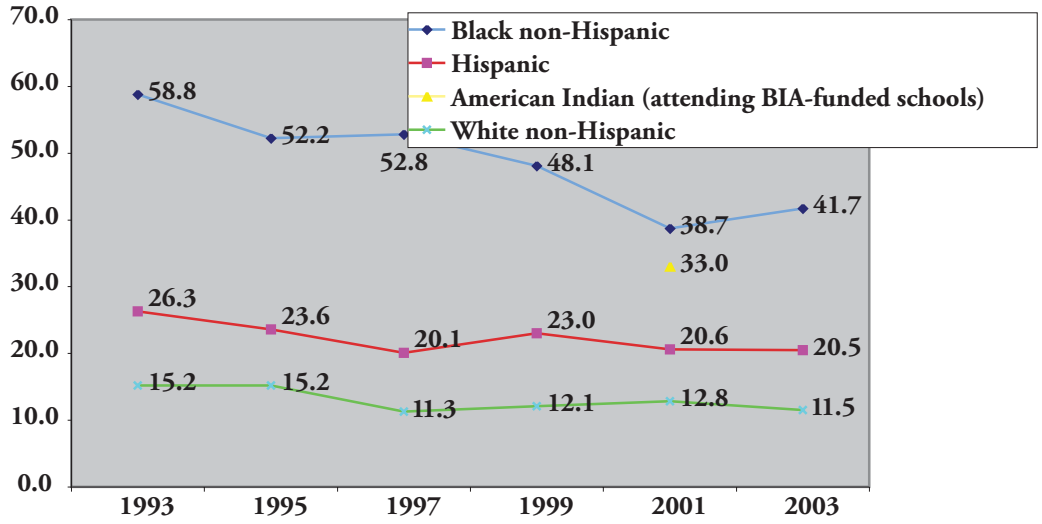
Source: Abma et al. 2004.

FIGURE 20
Distribution of females ages 18-24 who had sex before age 20, by how much first intercourse was wanted, by race/ethnicity, 2002
Percent



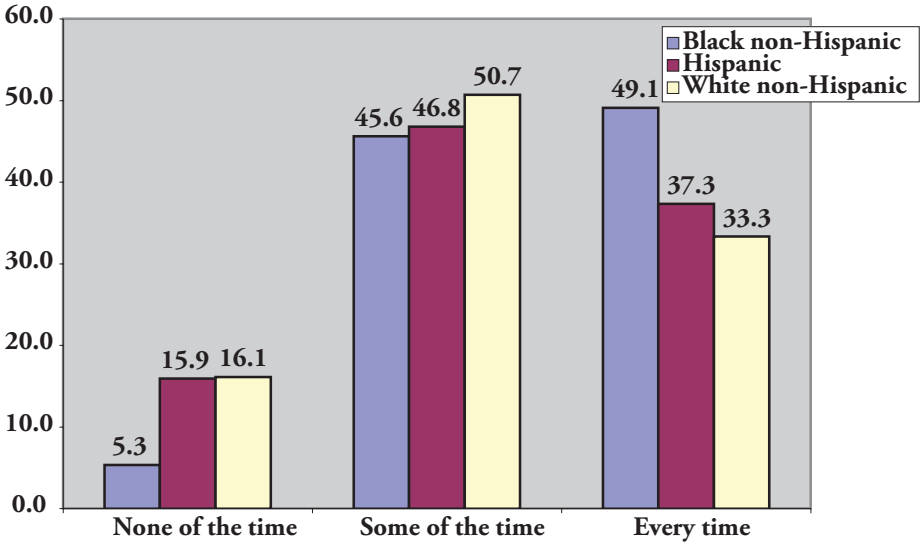
Source: Abma et al. 2004.

FIGURE 21
High school males who have had four or more sexual partners during their lifetimes, by race/ethnicity, 1993, 1995, 1997, 1999, 2001, and 2003
Percent



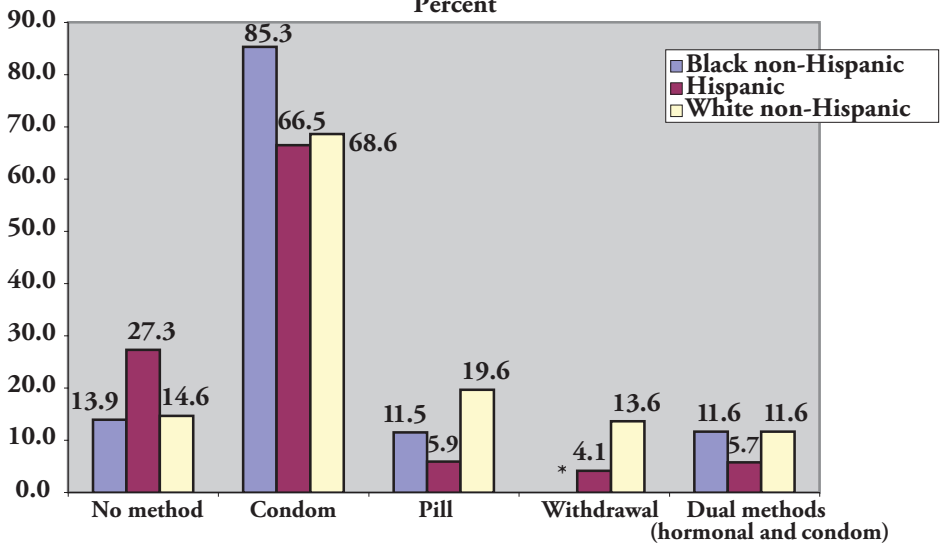
Sources: Kann et al. 1995; Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; Grunbaum et al. 2004; and Shaughnessy, Branum, and Everett-Jones 2001.

FIGURE 22
Condom use by never-married males ages 15-24 who had sexual intercourse in the past 12 months, 2002
Percent



Source: Abma et al. 2004.

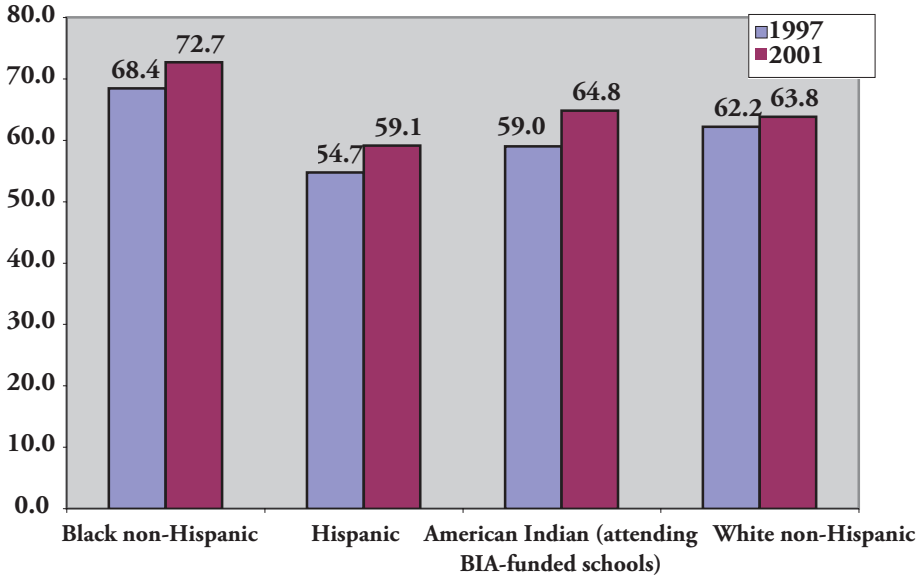
FIGURE 23
Never-married males ages 15-19 who have ever had sexual intercourse and percent who used the specified method of contraception at first sexual intercourse, by race/ethnicity, 2002
Percent



*Percent for black non-Hispanic males does not meet standard of reliability or precision.

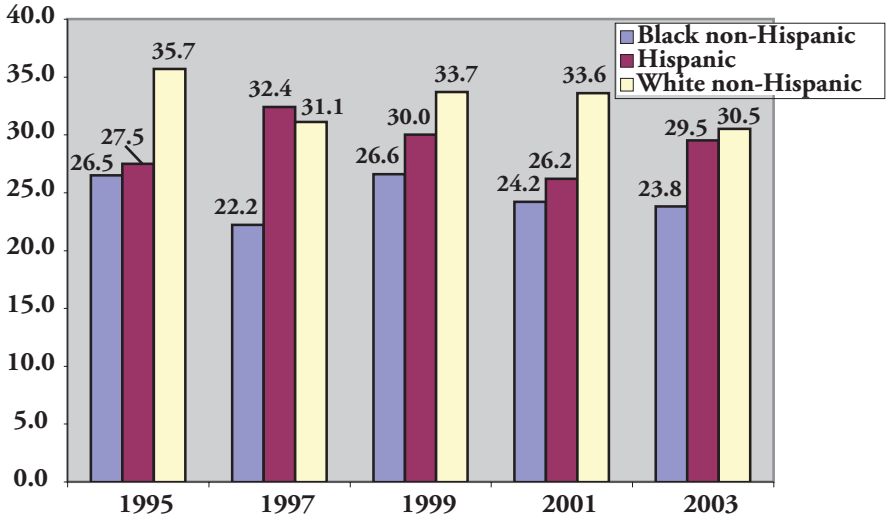
Source: Abma et al. 2004.

FIGURE 24
Condom use among high school males during last sexual intercourse, by race/ethnicity, 1997 and 2001
Percent



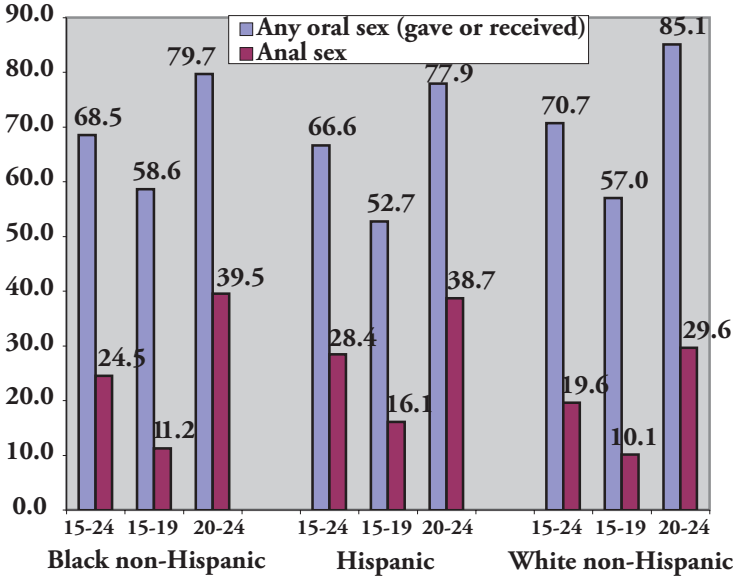
Sources: Kann et al. 1998; Grunbaum et al. 2002; Bureau of Indian Affairs 1997; and Shaughnessy, Branum, and Everett-Jones 2001.

FIGURE 25
Male high school students who used alcohol or drugs at their last sexual intercourse, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



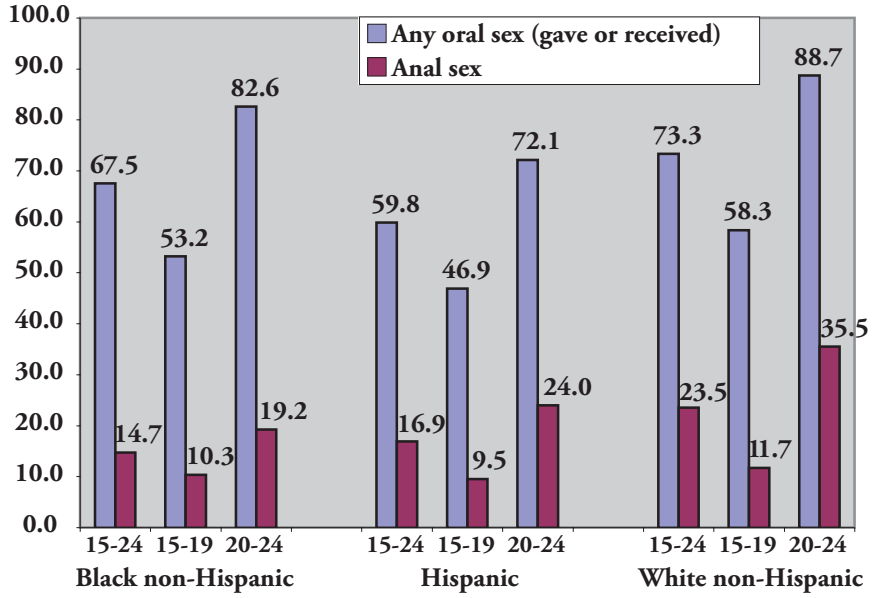
Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.

FIGURE 26
Males ages 15-24 who have had oral or anal sex with a female, by race/ethnicity, 2002
Percent



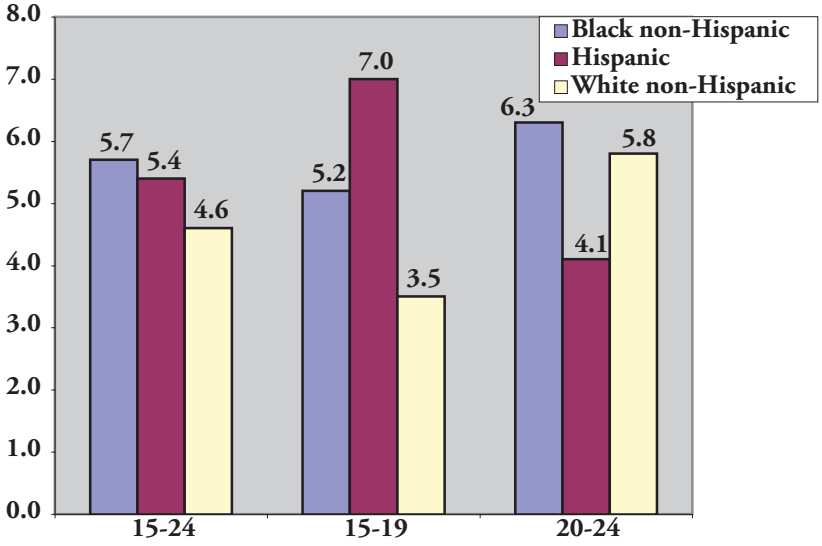
Source: Mosher, Chandra, and Jones 2005.

FIGURE 27
Females ages 15-24 who have had oral or anal sex with a male, by race/ethnicity, 2002
Percent



Source: Mosher, Chandra, and Jones 2005.

FIGURE 28
Male same-sex sexual contact* ages 15-24, by race/ethnicity, 2002
Percent



*Any oral or anal sex with a male.

Source: Mosher, Chandra, and Jones 2005.

Challenges in Interpreting Sexual and Reproductive Health Data

Our knowledge about the sexual and reproductive health of young men of color (and of all young people) comes primarily from data collected by government agencies. As with all human endeavors, data collection and analyses of data about health behaviors and outcomes are subject to biases and errors. One commonly encountered form of bias results from reliance on self-reports about sensitive and personal topics. Although this reliance is defensible (and perhaps without alternative), it may impart biases (both overstating and understating) to the data collected. Another bias that affects analyses of data about the sexual and reproductive health of young men of color is the failure to capture or account for unmeasured influences (e.g., the media, racism) on the associated behaviors and outcomes.

The first section below explores how data about sexual and reproductive health are collected and the implications of these collection methods for our knowledge about young men of color. The following section discusses unmeasured influences on relevant health behaviors and outcomes and how their absence from analyses shapes what we accept as knowledge about the sexual and reproductive health of young men of color.

Data Collection

Data about sexual and reproductive health are generally classified as either behavioral or outcome. Behavioral data are most commonly gathered by surveying samples of adolescents and adults. Because the entire population is not polled, sampling design decisions may limit the knowledge acquired via these surveys. Outcome data (e.g., about STIs and HIV/AIDS) usually are collected by local health agencies and provided to the federal government for compilation and dissemination. The collection process as well as analyses of both behavioral and outcome data present challenges that are described below.

Behavioral Survey Data

When collecting survey data about sexual and reproductive health behaviors, decisions made to save money or to provide the greatest amount of information for the population at large may limit the quality and scope of the knowledge generated about populations such as young men of color. Learning about young men of color requires a sample that includes males, young persons, and persons of various racial and ethnic groups. In addition, it requires a sample that is large enough to support analyses for all of the subcategories of gender by age and by race, or to support the estimation of separate statistical models for various subgroups of young men of color. The major surveys that collect data about sexual and reproductive health behaviors among adolescents have not always included members of all of the gender, age, and race subgroups in large enough numbers to enable the desired research.

In addition, surveys about sexual and reproductive health behaviors rely on self-reports. Self-reported information about these health behaviors among youth is often biased because young males tend to exaggerate their sexual acumen and experiences, while young females tend to understate the same.[39] Thus, self-reported survey data may yield a distorted and inflated sense of the behaviors in which young men of color engage.

Surveys to collect data about sexual and reproductive health behaviors also are most often conducted at a single point in time. Analyses based on these surveys—known as cross-sectional analyses—consequently reflect only this single point in time. Cross-sectional analyses limit our knowledge about the health of young men of color because they do not allow for the examination of change and the assessment thereby of cause and effect. Longitudinal surveys—i.e., surveys replicated over time with defined population(s)—are the preferred approach for establishing causal relationships, even though these studies are plagued by sample attrition over time, which limits their analytic power.[40] Although many cross-sectional studies address similar issues, their findings often are difficult to compare.

[39] Brown and Sinclair 1999; Laumann et al. 1994; Smith 1992; and Wiederman 1997.
[40] Li, Feigelman, and Stanton 2000; Miller et al. 1997; and Mott et al. 1996.

Many survey samples are not comparable or are so small that their results are not generalizable. Other studies employ modeling techniques whose results are not comparable.

For example, conflicting results from recent research on the influence of mothers working outside the home on the age of male teens at the time of sexual initiation may stem from differences in the methods used to collect the cross-sectional data on which these analyses are based. Using the 1991 National Survey of Men (NSM-1), Bakken and Winter found that African American males whose mothers worked outside the home for at least six months (when the youth were between the ages of 5 and 15 years) initiated sex earlier than African American males whose mothers did not report working outside the home.[41] In contrast, in their analysis of data from Wave 1 of the National Longitudinal Study of Adolescent Health (conducted in 1994-95 and commonly known as Add Health), Cubbin and colleagues found a modest relationship (p=.08) between a higher concentration of working women and lower odds of sexual initiation among teenage males of all racial/ethnic groups.[42]

Although both of these studies were based on cross-sectional, nationally representative data collected in the first half of the 1990s, the sampling techniques and the analytical approaches differed. The 1991 NSM-1 used by Bakken and Winter oversampled black men ages 20-39, and the authors analyzed data for the black men (1,125) who indicated that they were heterosexual and that they had engaged in sexual intercourse at least once.[43] Cubbin and colleagues, on the other hand, used Add Health data for a sample of 14,151 youth in grades 7-12 to estimate separate regression models for males and females. Race/ethnicity (defined as Black, Cuban American, Mexican American, Puerto Rican, and White) was one of the independent variables in the gender-specific models estimated. Because the sample was not large enough to support the estimation of separate models for each subpopulation of men of color, Cubbin and colleagues did not report findings about separate groups of young men of color.[44] Thus, it is not possible to determine whether: a) the relationship suggested by Cubbin and colleagues between the working status of a mother and sexual initiation of her son (i.e., a higher concentration of working mothers is positively associated with lower odds of sexual initiation) is the same for young men of color as it is for all males; b) the relationship is as reported in Bakken and Winter among African American males (i.e., mothers working outside the home are associated with earlier sexual initiation); or c) there is no relationship between the variables.

- ***Gender***

Data for both males and females are not routinely and systematically collected in surveys about adolescent sexual and reproductive health. Because teen pregnancy and female teens historically have been the foci of adolescent reproductive health interventions, data have not always been collected about teen males. Only since the 1990s have reproductive health surveys begun to interview males as well as females.

Although reproductive health surveys per se have not historically collected data for both females and males, since the mid-1960s, the National Longitudinal Surveys (NLS) have collected data from young men and young women (ages 14-24) on a variety of topics. Employment patterns such as leaving and re-entering the labor force are the primary focus of the NLS, but these surveys also have collected information about educational experiences, career choices, and marital and fertility histories through their core and supplemental questionnaires. Some of the published research about adolescent reproductive health is based on NLS data from various years.[45]

The National Survey of Family Growth (NSFG), a survey of sexual and reproductive health for populations between the ages of 15 and 44, provides an example of a long-conducted survey that only recently began collecting data about males. Periodically conducted since 1973, the NSFG included males for the first time in its 2002 sample. Cycle 1 of the NSFG (1973) interviewed 9,797 women ages 15-44, with an oversampling of blacks (39 percent).[46]

[41] Bakken and Winter 2002.
[42] Cubbin et al. 2005.
[43] Tanfer 1993.
[44] Cubbin et al. 2005:132.
[45] Ahn 1994; Day 1992; Klepinger, Lundberg, and Plotnick 1995; Mott et al. 1996; Pirog-Good 1995; Rosenbaum and Kandel 1990; and Trent 1994.
[46] Hendershot 1981.

Although total NSFG sample sizes decreased in Cycle 2 (1976), Cycle 3 (1982), and Cycle 4 (1988), the Cycle 5 (1995) survey included 10,847 interviews, with an oversampling of black non-Hispanic and Hispanic females.[47] Cycle 6 (2002) interviewed a sample of 12,571, including both women (7,643) and men (4,928). Among the 4,928 males surveyed, nearly half (47 percent) were men of color (primarily Hispanic, at 22.8 percent, and non-Hispanic black, at 18.9 percent). Thus, both Hispanics and non-Hispanic blacks were oversampled for the NSFG Cycle 6. Comparable proportions of women interviewees were non-Hispanic black and Hispanic.[48]

Since the NSFG only began surveying men in 2002, it yields data over time for females but not for males.[49] The inclusion of males in the 2002 NSFG may be a watershed event, however. Including males in all future waves of the NSFG (there are plans to collect annual survey data from 4,000 people beginning in 2006) could provide an ongoing series of comprehensive and comparable data about young males.[50] Such a longitudinal data set could eliminate the need to base contemporary analyses of the sexual and reproductive health of young men (i.e., analyses published since 2000) on surveys undertaken as long ago as the 1991 NSM or on cross-sectional surveys alone.

Data about the sexual and reproductive health behaviors of young males have been available since 1988, however, from a variety of male-only surveys. The National Survey of Adolescent Males (NSAM), conducted in 1988, 1990-1991, and 1995, yields longitudinal data about never-married males ages 15-19. The 1988 NSAM used a nationally representative sample of 1,880 males, with an oversampling of black and Hispanic adolescent males. The survey consisted of face-to-face interviews as well as a self-administered questionnaire to cover some of the more sensitive questions. Partner-by-partner sexual and contraceptive histories, demographic and family background, and HIV-related and pregnancy-related attitudes and knowledge were collected by the survey.[51] In 1995, a total of 1,290 males (by that time ages 22-26) responded to the third survey, representing a response rate of nearly 70 percent of the original 1,880 sample.[52]

Another all-male survey, the 1991 NSM-1 (National Survey of Men) was the first major national survey to look at sexual and reproductive health for young men beyond adolescence. The NSM-1 collected data from a national probability sample of 3,321 men ages 20-39, including an oversample of black men.[53] The NSM-1 questionnaire collected information about sexual initiation and current exposure; current wife or partner; previous marital relationships; other nonmarital sexual partners; nonsexual partners; health and risk-taking behavior; attitudes, perceptions, and knowledge; and condoms.[54] A follow-up NSM was conducted in 1993.

By the middle of the 1990s, both the Youth Risk Behavior Survey (YRBS) and Add Health had incorporated questions and measures to more fully reflect the role of adolescent males. For example, in addition to asking high school females if they ever had been pregnant, the 1995 YRBS also asked high school males if they had impregnated someone. Add Health, first conducted in 1994-1995, used large enough samples of young males (and young females) and of populations of color to support analyses on a range of sexual and reproductive health topics, although not for every racial/ethnic group or for all subgroups such as men of color.[55]

In summary, data about the sexual and reproductive health behaviors of young men of color have been provided in male-only surveys (e.g., National Survey of Men, National Survey of Adolescent Males), as well as in surveys including both male and female respondents (e.g., National Longitudinal Study of Adolescent Health, or Add Health; National Survey of Family Growth, or NSFG). In addition to these surveys focused on sexual and reproductive health, marital and fertility histories of young males and females have been available since the mid-1960s from the National Longitudinal Surveys, whose primary emphasis is employment patterns. Unlike the

[47] Chandra et al. 1999; Hendershot 1981; Horn and Mosher 1986; and Mosher and Pratt 1993.
[48] National Center for Health Statistics 2002.
[49] Cubbin et al. 2005.
[50] Flanigan et al. 2005.
[51] Sonenstein et al. 1998.
[52] Bradner, Ku, and Lindberg 2000.
[53] Tanfer 1993.
[54] Tanfer 1993.
[55] Cubbin et al. 2005.

NSFG, which has been conducted at regular intervals since 1973, the male-only surveys were conducted for several years in the late 1980s through the mid-1990s, but have not been conducted since. Thus, the best hope for a longitudinal data base about the sexual and reproductive health behaviors of young men of color may lie with the NSFG. While the NSFG first included males in 2002, annual data collection is expected to begin in 2006.

• *Age*

Another pivotal decision that is made in the collection and analysis of behavioral survey data about the sexual and reproductive health of young men of color concerns which age groups of males to include. As noted earlier, this report typically defines "young" as 13-29 years of age, thereby including adolescents as well as post-adolescent young males. Adolescence is defined as ages 10-19 years, although the core ages for much of the reported data about adolescents are 15-19 years.[56] All of the data about the sexual and reproductive health behaviors and outcomes of young men of color are not available for these ages, however. Some data are for 15- to 24-year-olds as a group, other data are for 15- to 19-year-olds as a cohort, and yet other data are for the broader 15- to 29-year-old age group. Such inconsistencies in the definition of age categories for which topical data are provided for young men of color often make it difficult to analyze and compare trends in sexual and reproductive health behaviors.

Behavioral surveys—and analyses based on these surveys—vary in their definitions of "young," and these variations have implications for the findings reported. The Youth Risk Behavior Survey (YRBS), a survey administered only to youth in high school, provides one example. Selecting high school students as the survey population captures youth in the 9th through 12th grades (generally 14- to 17-year-olds). Some 18- and 19-year-olds are likely to be included in the survey as well. Published survey data are reported by grade in school (9th, 10th, 11th, and 12th), however, not by age groups, such as 14- to 15-year-olds, 16- to 17-year-olds, or 18- to 19-year-olds. YRBS data are therefore difficult to compare with age-specific data from other sources. In addition, the exclusive focus in YRBS on in-school youth overlooks the health of out-of-school youth (both males and females) who are more likely to have certain STIs than youth in schools.[57]

Defining the category "young" beyond the teen years also is problematic. Recent neuroscience has revealed that the human brain is not fully developed until a person is in his/her mid-20s.[58] Accordingly, it could be argued that the age cohorts that define "young" should be extended to at least age 25. Increases over time in the age at first marriage of both males (age 26.7) and females (age 25.1) might suggest that the category "young" should be extended to even older ages.[59] Such an extension of the definition of "young" could be justified as reflecting the increased number of years for sexual exploration (before marriage) during which the sexual and reproductive health behaviors and outcomes of young men and women might be of concern to the public at large. The frequency with which female teens of color report having older sex partners also supports the case for expanding the definition of "young" to include some of these older partners and their behavior.[60]

Extending the upper age limit on the category "young" also may be warranted because of differences in marriage rates and patterns of sexual partnering between people of color and whites. For instance, marriage rates are generally lower for young men of color than for white men, as data for men in their 20s illustrate.[61] In the early 1990s, although 70 percent of all young men ages 20-24 reported that they were "never married and not cohabiting," more than three-fourths of black men (76 percent) reported this, compared with 69 percent of white males and 68 percent of Hispanic males, whose shares coincided with the average for all men ages 20-24. Among men ages 25-29, the racial/ethnic gaps were greater, with 59 percent of black men "never married and not cohabiting," far in excess of the average (39 percent) and the shares reported by Latino men (47 percent) and white men (34 percent). Although comparable data more recent than the early 1990s were not found, these patterns may not have changed significantly since that time.

[56] Leigh and Andrews 2002; and National Adolescent Health Information Center 2005.
[57] Pack et al. 2000.
[58] Gogtay et al. 2004; and Weinberger, Elvevåg, and Giedd 2005.
[59] The Alan Guttmacher Institute 2002.
[60] DiClemente et al. 2002; Harawa et al. 2003; Marin et al. 2000; and Taylor et al. 1999.
[61] The Alan Guttmacher Institute 2002.

The incidence of STIs represents another complicating factor in determining the definition of "young." This incidence varies by age group in ways that suggest the need for a more thorough understanding of what goes on within each of the racial/ethnic groups and what happens as "young" men age through these cohorts. For example, rates of some STIs (chlamydia and gonorrhea) are at their peaks among young men of color ages 20-24 and decline after age 24. The pattern with syphilis in 2004 differs, however, with rates increasing as all of the racial/ethnic groups age. In other words, 25- to 29-year-olds had higher rates than 20- to 24-year-olds, except among American Indians/Alaska Natives (whose peak rates were reported for 20- to 24-year-olds in 1999 and 2002). Looking at all young men of color without age disaggregation would obscure these differences.

- ***Race/ethnicity***

The inclusion of persons of various racial/ethnic groups in survey samples for data collection is clearly necessary to allow us to analyze the sexual and reproductive health of men of color. Many surveys interview only small samples of men of color, however, or interview only African American and Latino males, for example, rather than men of color of all racial and ethnic groups. As the U.S. population changes to contain greater numbers of people of color and immigrants, we need to modify these data collection protocols to maintain a viable knowledge base.

The following major racial/ethnic categories were established in 1997 by the Office of Management and Budget (OMB) Directive No. 15 for data collection and for population-based analyses conducted by federal government agencies: Hispanic or Latino Americans, and non-Hispanic racial groups including American Indians or Alaska Natives, Asian Americans, Black or African Americans, and Native Hawaiian or Other Pacific Islander Americans.[62] Despite this attempt to standardize the racial/ethnic categories for which data are provided, these categories have not yet become the norm. In addition, even these broad groupings do not isolate the major subpopulations of Latinos (i.e., Mexicans, Puerto Ricans, and Cubans) and Asians (i.e., Chinese, Filipinos, Asian Indians, and Koreans). Nor do these categories isolate subpopulations of Native Hawaiians or Other Pacific Islanders (e.g., Guamanians) and of American Indians or Alaska Natives (e.g., Cherokee or Inuit).

The OMB Directive No. 15 categories are more extensive than the population categories for which data are collected in many surveys. For example, data about STIs continue to be provided for Asian Americans and Pacific Islanders as a single category (the standard usage in the era before OMB Directive No. 15), rather than for Asian Americans and for Native Hawaiian or Other Pacific Islander Americans separately. At the same time, using samples too small to allow analyses of the subpopulations of major racial/ethnic groups limits the scope of the information gathered and the meaningfulness and generalizability of the associated research findings. This is especially problematic for groups such as American Indians/Alaska Natives, who are more likely to be understudied than are other young men of color.[63]

Cost is a major determinant of survey sample sizes. As the various populations in the United States about which we know little increase in number, however, the usefulness of surveys that sample insufficient numbers of these subgroups greatly diminishes. If limited geographic dispersion is part of the reason that national survey samples do not capture large enough numbers of selected subpopulations, oversampling in locales in which these populations dominate is one strategy that can be used to gather useful, generalizable information about the many subpopulations of color. The Hispanic HANES (Health and Nutrition Examination Survey), administered between 1982 and 1984, provides one example of this approach. The H-HANES captured 76 percent of the 1980 Spanish-origin population by collecting data in the areas in which the major Latino subpopulations resided at that time—i.e., Arizona, California, Colorado, New Mexico, and Texas for Mexican Americans; New York, New Jersey, and Connecticut for Puerto Ricans; and Dade County, Florida, for Cuban Americans.[64]

[62] Office of Management and Budget 1997.
[63] Chewning et al. 2001; and Saewyc et al. 1998.
[64] Leigh and Jiménez 2002.

Outcome Data

The manner in which sexual and reproductive health outcome data are collected also may lead to the misinterpretation of the findings for young men of color. Outcome data are most commonly provided by local public health departments to federal agencies who collate and process these data to determine rates for selected outcomes, such as STIs. Outcome data for people of color are reported to the Centers for Disease Control and Prevention (CDC) more often than the corresponding data for whites for two interrelated reasons. One is that lower-income populations are more likely than higher-income populations to use public health clinics and other facilities that will report STI cases to the CDC. The other is that people of color are more likely than whites to have lower incomes.[65] The resulting reporting pattern suggests that data about the sexual and reproductive health outcomes of young men of color may be accurate but may be viewed in an inappropriate context because of the underreporting of data for young white males.

Similar to behavioral surveys, outcome data collection may reflect a gender bias against males. With outcome data, one form of bias relates to the recommendations for STI screening. For example, sexually active young women—but not sexually active young men—are routinely screened for chlamydia trachomatis. Studies that examined the extension of this screening to adolescent boys (ages 14-18) attending pediatric clinics for routine health maintenance visits at an HMO (health maintenance organization) revealed the efficacy of urine-based testing for young males.[66] Although rates of chlamydia are high primarily among both young women and young men of color, and despite a 1984 study suggesting the value of screening both groups to minimize the overall rates, emphasis historically has been placed on screening females rather than males.[67]

The failure to report outcome data fully disaggregated by age, race, and gender may be the inevitable result of small reported totals and related confidentiality concerns. Nonetheless, the way in which these data are reported serves to limit our current knowledge about the sexual health of young men of color. For example, the data about HIV infection and AIDS among young men of color reported in this document are from 2001. This is because 2001 is the most recent year for which data for the relevant subcategories of age by race and by gender were provided by the CDC.[68] More aggregated HIV/AIDS data (e.g., for race by gender subgroups only, or for age subgroups only) are available through December 2004. Thus, the decision not to report disaggregated data about HIV infection and AIDS results in the use of data for young men of color that are three years older than similar data for the general population.

The manner in which behavioral surveys are conducted and outcome data are collected by age, gender, and race/ethnicity influences our knowledge of all youth populations, not just young males of color. Examples are provided below of the analytical and interpretive challenges that result from the use of available behavioral information and outcome data about the sexual and reproductive health of young men of color.

Examples

The first example concerns the data about condom use and STI incidence. When never-married African American, Hispanic, and white males are compared, African American males are the most likely to report condom use. A 2002 survey found this to be true among 15- to 24-year-old males who had sexual intercourse within the past 12 months and reported on the frequency (every time, some of the time, or none of the time) of their condom use (Figure 22). This was true among 15- to 19-year-old males who reported that they had used a condom at first sexual intercourse, as well (Figure 23).[69] The finding also was true among high school males (black, white, Hispanic, and American Indian/Alaska Native) who reported their condom use during last sexual intercourse,

[65] Brackbill, Sternberg, and Fishbein 1999; U.S. Census Bureau 2003; and Centers for Disease Control and Prevention 2000.
[66] Tebb et al. 2004; and Tebb et al. 2005.
[67] Adger et al. 1984; and Burstein et al. 1998.
[68] Centers for Disease Control and Prevention 2002.
[69] Abma et al. 2004.

according to 1997 and 2001 survey data (Figure 24).[70] Despite greater reported condom use among African American males, however, rates for chlamydia, gonorrhea, and syphilis among African American males are many times the rates reported both by other young men of color and by young white males. How can these data be reconciled? Are the self-reports of condom use false? Are STIs transmitted among African American males primarily by sexual activity other than vaginal sexual intercourse, for which condom use is less frequent? Can the large racial/ethnic gaps in STI rates be fully explained by the frequency with which data for young white men are not included in the nation's public health data collection system? To explain these seemingly paradoxical findings, questions such as these must be addressed.

A second example is provided by the fluctuations in a single outcome measure—e.g., reported syphilis rates for young American Indian and Alaska Native males between 1999 and 2004 (Figures 9, 10, and 11). Although rates for most groups of young men show a steady trend, the rates for American Indians and Alaska Natives fluctuate to a degree that suggests that the population is too small to provide robust incidence measures.[71] American Indians and Alaska Natives frequently are misidentified by health professionals.[72] Attributing STI cases reported by American Indians/Alaska Natives to other racial/ethnic groups also may influence the reported outcome data.

Characteristics of the American Indian population included in behavioral surveys sometimes limit the usability of the survey findings. For example, when conducting the YRBS for American Indian youth in 1994, 1997, and 2001, the Office of Indian Education Programs (OIEP) in the Bureau of Indian Affairs (BIA) surveyed only youth attending BIA schools. Thus, the BIA/OIEP YRBS has both the usual YRBS bias associated with sampling only an in-school population and the bias of representing only American Indians attending BIA schools, thereby excluding urban Indians. These sampling decisions contribute to the difficulty of generalizing YRBS findings to all American Indian and Alaska Native adolescents.[73]

Other examples relate to the meaning to be imputed to self-reported data about the sexual and reproductive health of adolescents. In general, one might expect that collecting self-reported data retrospectively would introduce inaccuracies into survey results for a variety of reasons, including unwillingness to divulge certain sexual behaviors or experiences and loss of detailed memory about past events.[74] Self-reported YRBS data about pregnancy (females) and about having impregnated someone (males) illustrate one of the problems that may occur with self-reported data (Figures 1 and 2). One might assume that high school males would be the sexual partners of high school females, and, therefore, the reporting of impregnation and pregnancy should be the same for males and females. According to these data, however, high school males are a little less likely to report having impregnated someone than are high school females to report having ever been pregnant. If we adjust for both the tendency of males to exaggerate the frequency and nature of their sexual experiences and the tendency of females to understate the same, this gap would widen.

One plausible explanation for the gap is that female teens (black non-Hispanic, Hispanic, and white non-Hispanic) are likely to be impregnated by older men.[75] Teen childbearing is more common among females who had a first sexual relationship at age 15 or younger with an older male than it is among other sexually experienced female teens.[76] Yet, young males also report relationships with older individuals. Teenage males (of all racial groups) who reported that their first sexual experience occurred at age 15 or earlier with an individual three or more years older represented one-fourth (26 percent) of all teens whose first sexual relationship occurred at age 15 or younger with someone three or more years older.[77] Three-quarters (77 percent) of the older males and females with whom teens ages 15 or younger reported having sex were also still in their teens, however.[78] Since teenage females and

[70] Bureau of Indian Affairs 1997; Grunbaum et al. 2002; Kann et al. 1998; and Shaughnessy, Branum, and Everett-Jones 2001.
[71] Centers for Disease Control and Prevention 2004.
[72] Frost et al. 1994; and Hodge, Weinmann, and Roubideaux 2000.
[73] Shaughnessy, Branum, and Everett-Jones 2001.
[74] Rosenbaum and Kandel 1990.
[75] Lindberg et al. 1997.
[76] Manlove et al. 2005.
[77] Manlove et al. 2005.
[78] Manlove et al. 2005.

males both have sex with older partners, and the majority of these partners are in their teens, the hypothesis stated above—that the gap between males reporting having impregnated someone and females reporting having been pregnant can be explained by the fact that female teens have sex with older men—becomes unconvincing.

Self-reported data about in-school instruction on HIV/AIDS provides the final example of how nuanced the information about the sexual and reproductive health of young men of color is (Figures 29 and 30). Although males of each racial/ethnic group are slightly less likely than females to report being taught about HIV/AIDS at school, white non-Hispanic high school students (males and females alike) are more likely than either black non-Hispanic teens or Hispanic teens (also of both sexes) to report this instruction at school.[79] These self-reported findings may reflect the fact that, due to the residential racial segregation throughout the nation, young people of different racial/ethnic groups often are enrolled in separate school systems or attend different schools within a given system.[80] The systems in which white non-Hispanic youth are enrolled may be more financially able and therefore more likely to offer HIV/AIDS instruction than the systems that enroll youth of color. Unless we probe the meaning of these findings, however, we will not know whether they result from differences in school systems, differences in adherence to a statewide mandate for HIV/AIDS instruction in schools, or from something else altogether.[81]

Unmeasured Influences

Data related to the behavior and outcomes associated with the sexual and reproductive health of young men of color reflect what is visible to—or measurable in—the world when the information is gathered. These data do not, however, capture the causes of the observed outcomes and behaviors. For example, rates of pregnancy among American Indian females and rates of American Indian male teens acknowledging having caused pregnancy do not differ among American Indian adolescents by sexual orientation.[82] In other words, American Indian adolescents with non-heterosexual orientations (gay, lesbian, bisexual, and unsure) are equally likely to engage in sexual intercourse as those who are heterosexual. The nature of the influences that may account for these unanticipated findings are not fully understood. Unmeasured influences on the sexual and reproductive health behaviors and outcomes of young men of color are numerous and are noted briefly below, under the headings Macro, Familial, and Individual.

Macro

Macro influences on the sexual and reproductive health of young men of color include such diverse elements as racism, the media, poverty, cultural phenomena, and public school education. Although the many ways in which racism may influence the reproductive health of young men of color have not been specified or defined, research on the influence of racism on health in general, and on the influence of structural racism on youth development in particular, suggests that racism may play a prominent role.[83]

Messages about young men of color are imparted to society at large and to these youth in particular via many media outlets (e.g., radio, television, newspapers, the Internet). These messages influence the opinions and behaviors of all people in this country, and certainly could influence the behavior and, in turn, the sexual and reproductive health outcomes of these young men.[84] Although not specific to male youth, a RAND study of 12- to 17-year-olds found that African American youth who watched more television shows with storylines about safer sex or the risks and responsibilities of sexual activity were less likely to initiate intercourse in the subsequent year.[85] This finding suggests the power of television to contribute to positive behaviors and outcomes among adolescents.

[79] Grunbaum et al. 2002; Grunbaum et al. 2004; Kann et al. 1996; Kann et al. 1998; and Kann et al. 2000.
[80] Rickles et al. 2001.
[81] Leigh 2000; Gold and Nash 2001; and the Alan Guttmacher Institute 2005.
[82] Saewyc et al. 1998.
[83] Bennett et al. 2005; and Quiroz-Martinez, HoSang, and Villarosa 2004.
[84] Whitehead and Ooms 1999.
[85] Kaiser Family Foundation 2005.

The persistent poverty that besets people of color also worsens their health.[86] Consider recent research based on data gathered from the U.S. Department of Housing and Urban Development demonstration program Moving to Opportunity for Fair Housing (MTO). When low-income families relocated to areas with less concentrated poverty as a result of the program, mothers and their daughters—but not their sons—identified health improvements.[87] Most of the families served by MTO were African American (62.4 percent) or Latino (30.3 percent) and were headed by a single female parent (91.5 percent). Although not specific to sexual or reproductive health, this finding suggests a need for a greater understanding of how poverty influences health in general, and sexual and reproductive health in particular, for young men of color.

Cultural phenomena can and do influence the sexual and reproductive health of young men of color in many ways. One example is the existence of sociologic ghosts of "things over and done with" that assume a "seething presence" (of a murdered friend, a lost village, or a war remembered in detail) that presents itself and must be addressed.[88] Events such as slavery in the United States (for African Americans) or torture during war (for Vietnamese and Cambodian immigrants to the United States) can conjure up sociologic ghosts, which, in turn, must be dispatched to avert health-risk behaviors. Sociologic ghosts play a role in shaping contemporary behavior and outcomes for the affected populations along many dimensions, including health. For example, the sociologic ghost of the trauma of war not only may result in violent, anti-social behavior, but also may psychologically disable an affected male so that he is unable to work.

The acculturation process for immigrant groups coming to the United States—defined as adopting or adapting to U.S. culture, attitudes, and behaviors—provides a second example of cultural influences on male adolescent reproductive health behaviors and outcomes. Level of acculturation is related to a variety of characteristics (e.g., ethnic identity and language) as well as to risky behaviors (e.g., smoking, alcohol use, and engaging in sexual intercourse).[89] Risky behaviors appear to increase in frequency with subsequent generations residing in the United States. Findings seem to vary not only by broad racial/ethnic category of immigrant (e.g., Asian Americans or Latinos), but also by national origin within each broad immigrant category (e.g., Mexican or Cuban among Latinos). For Latino adolescents overall, acculturation in U.S. society seems to be a "mixed blessing." While third-generation Latino youth in the United States are more likely to have had sex than the offspring of immigrant parents, they also are more likely to use contraception than their counterparts in preceding generations.[90]

Exposure to sex education and to instruction about HIV/AIDS in schools is another macro factor that may have bearing on sexual-risk behaviors and, therefore, outcomes for young men of color. Although the relationships among knowledge, behavior, and outcomes remain indeterminant within the field of adolescent reproductive health (and other fields, as well), one would expect that persons entirely lacking in knowledge would engage in the behaviors and have the outcomes that they desire only by chance. Thus, information about acquired knowledge is necessary (although it may not be sufficient) for a full assessment of what has shaped behaviors and outcomes.

Although teacher and student surveys have been conducted to assess the content and implementation of sex education programs in schools throughout the nation, little data specific to race and gender subpopulations of students were identified.[91] One study found that, between 1988 and 1995 (NSAM data), formal sexual and reproductive health education became nearly universally available to adolescent males in school.[92] Even with the median age for this instruction dropping over the period from age 14 to age 13, however, many males did not receive instruction prior to first intercourse. Only 54 percent of black males—compared with 68 percent of Latino

[86] Braveman et al. 2001; Klebanov, Brooks-Gunn, and Duncan 1994; Krieger 1999; and Leigh 2004b.
[87] Orr et al. 2003.
[88] Gordon 1997.
[89] Driscoll et al. 2004.
[90] Harris 1999.
[91] Darroch, Landry, and Singh 2000; Hoff et al. 2000; and Landry et al. 2003.
[92] Lindberg, Ku, and Sonenstein 2000.

males and 76 percent of white males—reported receiving reproductive health education before their sexual debut. Thus, in many cases, formal sex education may be provided after it could be of most use to some males of color.

Familial

Characteristics of families and of intra-familial relationships, as well as family context (including educational attainment of parents, urban/suburban residence, and family income), influence the sexual and reproductive health behaviors of young males.[93] Most of the research about these influences, however, has been conducted for female adolescents.[94] Parental values, parental supervision, and parental aspirations for their children are all associated with various sexual and reproductive health behaviors and outcomes for female teens. Associations for female teenagers also have been found between reproductive health behaviors and sibling and extended-family relationships, as well as with family communication. For example, Rosenbaum and Kandel found that black female teens were more likely to have been pregnant if they had a sister who was a teen mother.[95]

Research on male adolescents reveals that, after sexual debut, male teens from two-parent families (both black and white) engaged in intercourse less frequently than their counterparts from single-parent families.[96] Interestingly, this pattern was not observed for female teens; having two parents in the home was not associated with the frequency of intercourse by female teens after their sexual debut.

Other research has found that black male youth (ages 18-21) who live with a biological father or with a stepfather were more likely to be sexually active at any age than their counterparts who did not live with either.[97] This same study found, however, that having a stepfather in the home significantly decreased the odds that an older Mexican American male (18-21) would make his sexual debut, while the presence of the biological father in the home was significant only for younger male Mexican American teens (ages 14-17), decreasing the likelihood of their sexual debut by 33 percent. Another study identified sibling influences on sexual and reproductive health behaviors and outcomes. Rosenbaum and Kandel found that black males with an older brother were more likely to have initiated intercourse by age 16 than were black males who did not have an older brother.[98]

These findings of Day, and Rosenbaum and Kandel, are based on data primarily from the National Longitudinal Survey of Youth (cohort of 2,711 youth ages 14-15 in 1979 and ages 19-20 in 1984) and thus should be comparable and generalizable. The findings seem to be somewhat contradictory or counterintuitive, however, and require additional research for clarification. In addition, these findings are for persons who were teenagers many years ago. The familial influences and the responses by today's teenagers may differ.

Individual

As a main determinant of sexual-risk behavior and reproductive health outcomes, many individual-level influences have been identified and analyzed. These influences include, but are not limited to the following: the peers with whom one interacts; one's physical, cognitive, emotional, and sexual development; childhood experiences of sexual, physical, or emotional abuse, if any; employment during the teen years; school experiences; and personal values.[99] Factors such as health insurance coverage and access to care, both of which clearly influence health outcomes, shift from a familial to an individual influence on sexual behaviors and outcomes as one ages through the 13- to 29-year-old cohort. As with other types of influences on reproductive health, the individual-level influences have been studied primarily for female adolescents and, when studied for male adolescents, African Americans have been the primary focus.

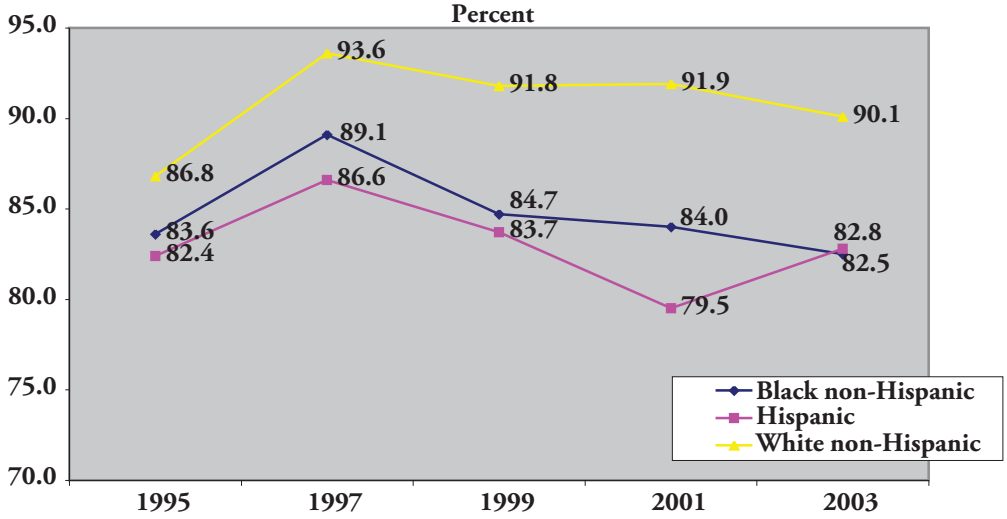
[93] National Adolescent Health Information Center 2005.
[94] Li, Feigelman, and Stanton 2000.
[95] Rosenbaum and Kandel 1990.
[96] Young et al. 1991.
[97] Day 1992.
[98] Rosenbaum and Kandel 1990.
[99] Bakken and Winter 2002; Raj, Silverman, and Amaro 2000.

Some research finds that individual factors do indeed matter. For instance, Perkins and colleagues found that African American male teens (but not African American female teens) were more likely to have had sex if they had negative feelings regarding the school climate.[100] These feelings were assessed through questions that asked students to rate statements (from strongly disagree to strongly agree) such as "My teachers really care about me," "My teachers don't pay much attention to me," and "I get a lot of encouragement at my school." In addition, other research has found that having experienced sexual, physical, or emotional abuse during childhood is associated with early sexual initiation among males and with subsequent adult sexual-risk behaviors.[101]

Personal values also are related to sexual-risk behaviors. A survey of males ages 15-19 who had never had intercourse revealed that sizable proportions of male teens of color had not had intercourse because it was against their religion or morals—21 percent of African Americans and 19 percent of Hispanics (Figure 31).[102] Male teens of color were less likely than white male teens (36 percent) to postpone intercourse because of religion or morals, however. On the other hand, "not wanting to get a female pregnant" was the reason to avoid intercourse cited among 42 percent of Latino male teens, 28 percent of black non-Hispanic male teens, and 23 percent of white non-Hispanic male teens. "Not having found the right person yet" was the reason cited by smaller but still sizable percentages of male teens avoiding intercourse—14 percent of black non-Hispanics, 19 percent of Hispanics, and 19 percent of white non-Hispanics. Personal values and other individual influences on sexual-risk behaviors warrant further study.

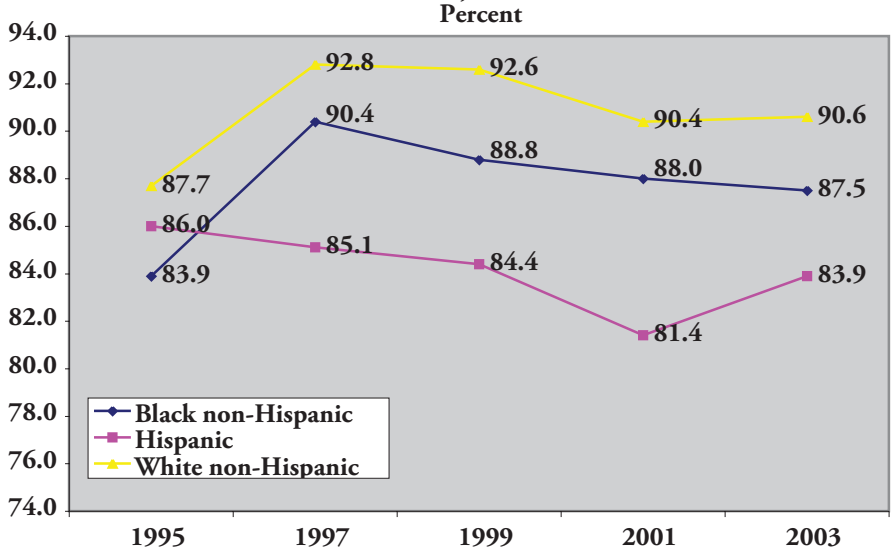
[100] Perkins et al. 1998.
[101] Felitti et al. 1998.
[102] Abma et al. 2004.

FIGURE 29
High school males taught about HIV/AIDS at school, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



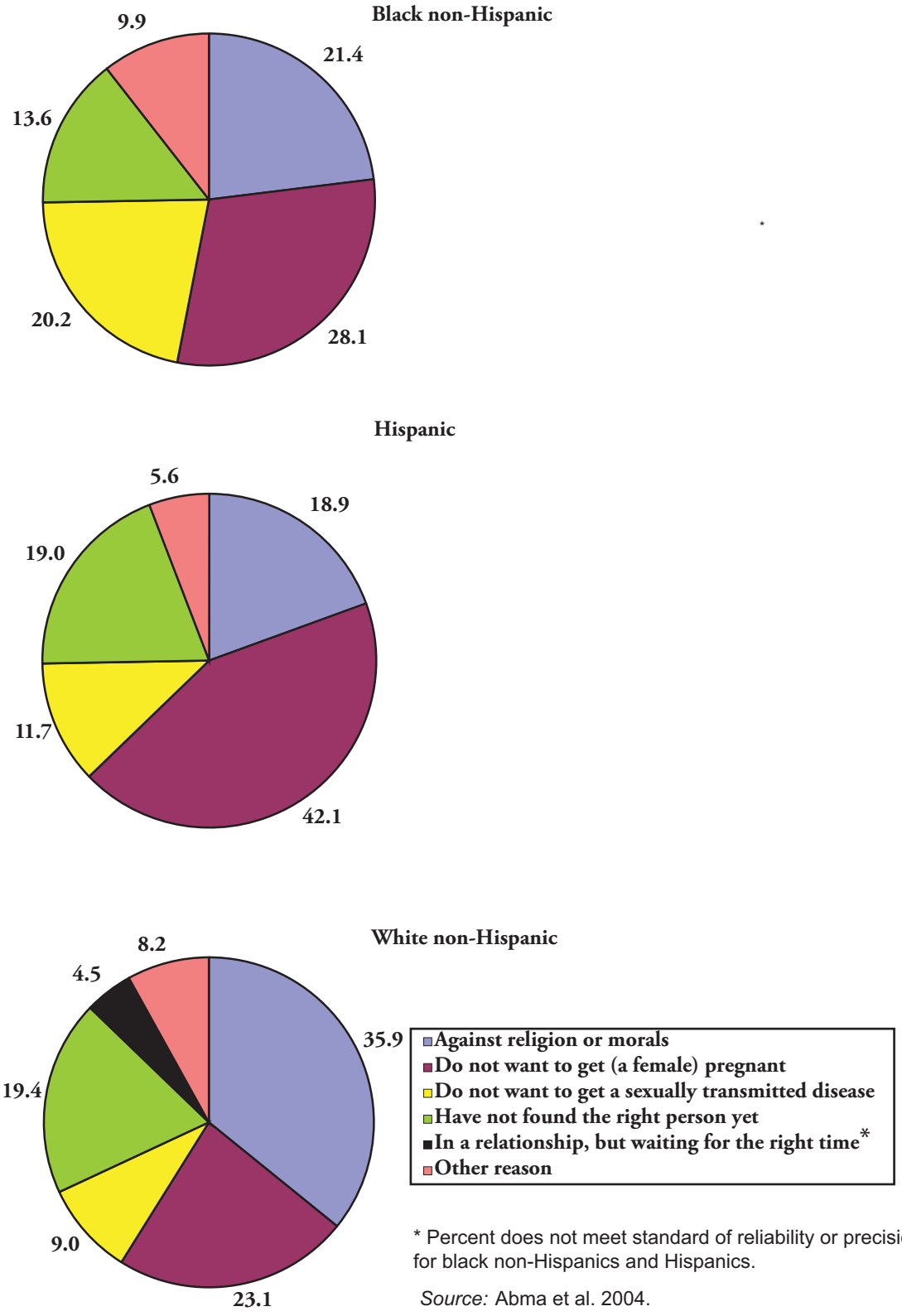
Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.

FIGURE 30
High school females taught about HIV/AIDS at school, by race/ethnicity, 1995, 1997, 1999, 2001, and 2003
Percent



Sources: Kann et al. 1996; Kann et al. 1998; Kann et al. 2000; Grunbaum et al. 2002; and Grunbaum et al. 2004.

FIGURE 31
Males ages 15-19 who have never had intercourse and main reason they have never had intercourse, 2002
Percent



* Percent does not meet standard of reliability or precision for black non-Hispanics and Hispanics.

Source: Abma et al. 2004.

Conclusion

Nearly two out of every five young males in the United States are males of color. Regardless of the age and racial/ethnic categorizations used, young men of color are more likely than their white counterparts to report sexual-risk behaviors and related health outcomes, such as STIs. This general pattern, however, is punctuated by findings such as young African American males reporting not only the highest use of condoms among young male subpopulations but also significant declines over the last five years in the incidence of gonorrhea.

Our knowledge base about sexual-risk behaviors and outcomes for young men of color is limited and biased in many ways, and the findings discussed in this report reflect some of these limitations and biases. For example, many behavioral surveys yield information for young men who are either African American or Latino, but not for American Indian or Alaska Native, Asian, or Native Hawaiian and Other Pacific Islander men. Other sources misidentify males of color and thereby either overstate or underreport data for them. Yet other sources underreport outcome data for whites and thereby skew the relative weight given to the outcome data for males of color.

What we know to date about the sexual and reproductive health of young men of color merely outlines the corpus of desired knowledge and understanding. We know the sexual and reproductive health outcomes (pregnancies caused, STIs) that young men of color present to the world, and we have a rudimentary understanding of some of the behaviors (number of partners) associated with these outcomes. To shade inside the outlined shapes, we need not only to examine the data at hand (and question and improve upon them), but also to develop other types of measures for some of the unmeasured influences on the sexual and reproductive health of young men of color. For example, we need to know more about:

- The most powerful influences on sexual and reproductive health behaviors of young men of color and whether these influences are the same as for young women of color;

- How (and why) sexual and reproductive health outcomes and behaviors differ for adolescent males (ages 13-19) and males ages 20-29;

- How to capture the experiences of adolescents of color more completely in sample surveys and in other data collection and analyses;

- How to adjust for biases due to self-reported data about sexual and reproductive health behaviors and outcomes; and

- How to measure the influence of macro factors (such as poverty, cultural phenomena, racism, and the media) on sexual and reproductive health behaviors and outcomes.

This report has suggested some likely first questions to ask and directions to take toward this end.

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About the Joint Center Health Policy Institute

The mission of the Joint Center Health Policy Institute (HPI) is to ignite a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives. HPI's goal is to help communities of color identify short-and long-term policy objectives and related activities in key areas. The Joint Center for Political and Economic Studies is a national, nonprofit research and public policy institution. Founded in 1970 by black intellectuals and professionals to provide training and technical assistance to newly elected black officials, the Joint Center is recognized today as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color.

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