



1-800-CDC-INFO (232-4636)
 In English, en Español
 24 Hours/Day
 cdcinfo@cdc.gov
 http://www.cdc.gov/hiv

January 2007

HIV/AIDS among African Americans

In the United States, the HIV/AIDS epidemic is a health crisis for African Americans. At all stages of HIV/AIDS—from infection with HIV to death with AIDS—African Americans are disproportionately affected compared with members of other races and ethnicities [1, 2].

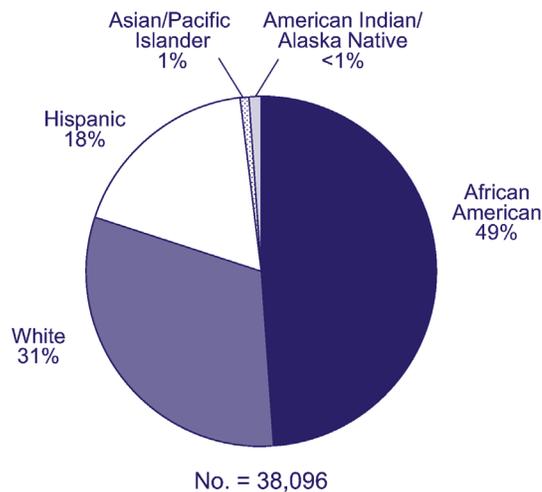
STATISTICS

HIV/AIDS in 2005

- According to the 2000 census, African Americans make up approximately 13% of the US population. However, in 2005, African Americans accounted for 18,510 (49%) of the estimated 38,096 new HIV/AIDS diagnoses in the United States in the 33 states with long-term, confidential name-based HIV reporting [2].*
- Of all African American men living with HIV/AIDS, the primary transmission category was sexual contact with other men, followed by injection drug use and high-risk heterosexual contact [2].
- Of all African American women living with HIV/AIDS, the primary transmission category was high-risk heterosexual contact, followed by injection drug use [2].

- Of the estimated 141 infants perinatally infected with HIV, 91 (65%) were African American (CDC, HIV/AIDS Reporting System, unpublished data, December 2006).
- Of the estimated 18,849 people under the age of 25 whose diagnosis of HIV/AIDS was made during 2001–2004 in the 33 states with HIV reporting, 11,554 (61%) were African American [3].

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005

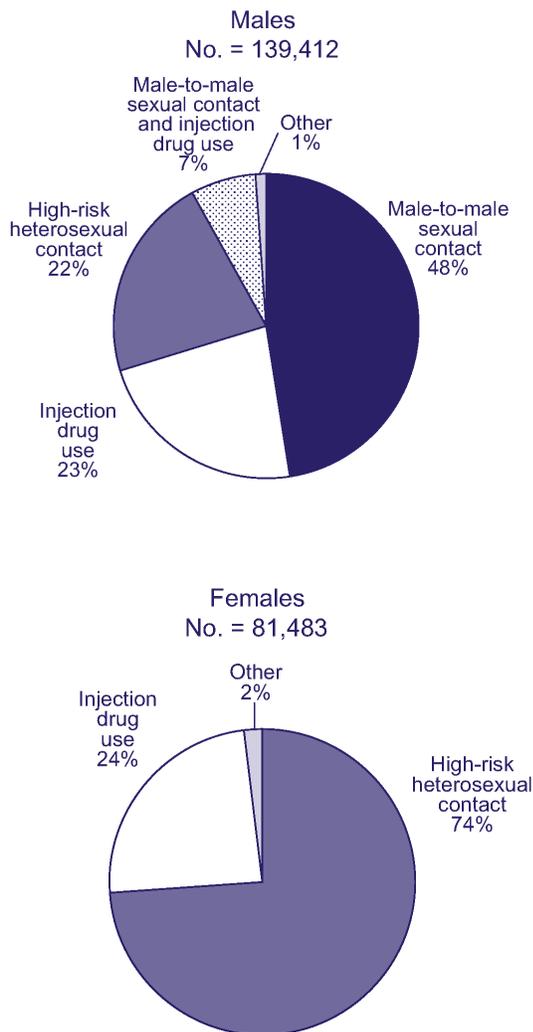


Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

*See the box (before the References section) labeled Understanding HIV and AIDS Data for a list of the 33 states.

HIV/AIDS AMONG AFRICAN AMERICANS

Transmission categories for African American adults and adolescents living with HIV/AIDS at the end of 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

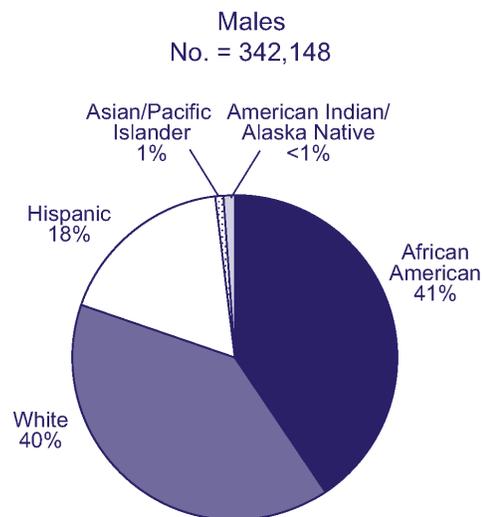
AIDS in 2005

- African Americans accounted for 22,030 (50%) of the estimated 44,198 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- The rate of AIDS diagnoses for African American adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics. The rate of AIDS diagnoses for African American women was nearly 24 times the rate for white women. The rate of AIDS

diagnoses for African American men was 8 times the rate for white men [2].

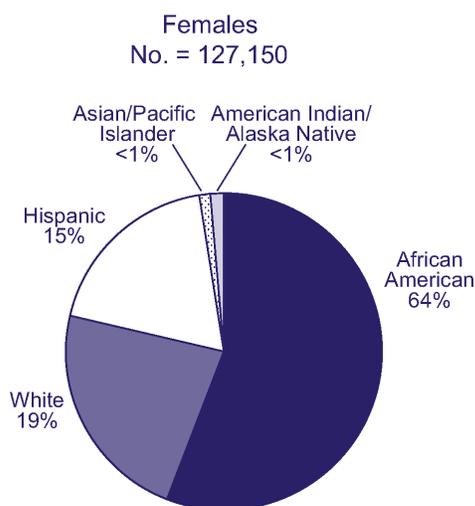
- The 188,077 African Americans living with AIDS in the 50 states and the District of Columbia accounted for 44% of the 425,910 people in the United States living with AIDS [2].
- Of the 58 US children (younger than 13 years of age) who had a new AIDS diagnosis, 39 were African American [2].
- Since the beginning of the epidemic, African Americans have accounted for 399,637 (42%) of the estimated 956,666 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- From the beginning of the epidemic through December 2005, an estimated 211,559 African Americans with AIDS died [2].
- Of persons whose diagnosis of AIDS had been made during 1997–2004, a smaller proportion of African Americans (66%) were alive after 9 years compared with American Indians and Alaska Natives (67%), Hispanics (74%), whites (75%), and Asians and Pacific Islanders (81%) [2].

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005 (cont.)



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

RISK FACTORS AND BARRIERS TO PREVENTION

Race and ethnicity, by themselves, are not risk factors for HIV infection. Even though HIV testing rates are higher for African Americans than for members of other races and ethnicities [4], rates of undetected or late diagnosis of HIV infection are high for African American men who have sex with men (MSM) [5].

African Americans are also more likely to face challenges associated with risk factors for HIV infection, including the following.

Sexual Risk Factors

African American women are most likely to be infected with HIV as a result of sex with men who are infected with HIV [2]. They may not be aware of their male partners' possible risk factors for HIV infection, such as unprotected sex with multiple partners, bisexuality, or injection drug use [6, 7]. Sexual contact is also the main risk factor for African American men. Male-to-male sexual contact was the primary risk factor for 48% of African American men with HIV/AIDS at the end

of 2005, and high-risk heterosexual contact was the primary risk factor for 22% [2].

Substance Use

Injection drug use is the second leading cause of HIV infection both for African American men and women [2]. In addition to being at risk from sharing needles, casual and chronic substance users are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol [8]. Drug use can also affect treatment success. A recent study of HIV-infected women found that women who used drugs, compared with women who did not, were less likely to take their antiretroviral medicines exactly as prescribed [9].

Lack of Awareness of HIV Serostatus

Not knowing one's HIV serostatus is risky for African American men and women. In a recent study of MSM in 5 cities participating in CDC's National HIV Behavioral Surveillance System, 46% of the African American MSM were HIV-positive, compared with 21% of the white MSM and 17% of the Hispanic MSM. The study also showed that of participating African American MSM who tested positive for HIV, 67% were unaware of their infection; of participating Hispanic MSM who tested positive for HIV, 48% were unaware of their infection; of participating white MSM who tested positive for HIV, 18% were unaware of their infection; and of participating multiracial/other MSM who tested positive for HIV, 50% were unaware of their infection [10]. Persons who are infected with HIV but don't know it cannot benefit from life-saving therapies or protect their partners from becoming infected with HIV.

Sexually Transmitted Diseases

The highest rates of sexually transmitted diseases (STDs) are those for African Americans. In 2005, African Americans were about 18 times as likely as whites to have gonorrhea and about 5 times as likely to have syphilis [11]. Partly because

of physical changes caused by STDs, including genital lesions that can serve as an entry point for HIV, the presence of certain STDs can increase one's chances of contracting HIV infection 3- to 5-fold. Similarly, a person who has both HIV infection and certain STDs has a greater chance of spreading HIV to others [12]. A recent CDC literature review showed that high rates of HIV infection for African American MSM may be partly attributable to a high prevalence of STDs that facilitate HIV transmission [5].

Homophobia and Concealment of Homosexual Behavior

Homophobia and stigma can cause some African American MSM to identify themselves as heterosexual or not to disclose their sexual orientation [13, 14]. Indeed, African American MSM are more likely than other MSM not to identify themselves as gay [5]. The absence of self-identification or the absence of disclosure presents challenges to prevention programs. However, data suggest that these men are not at greater risk for HIV infection than are African American MSM who identify themselves as gay [14, 15]. The findings of these studies do not mean that African American MSM who do not identify themselves as gay or who do not disclose their sexual orientation do not engage in risky behaviors, but the findings do suggest that these men are not engaging in higher levels of risky behavior than are other African American MSM.

Socioeconomic Issues

Socioeconomic issues and other social and structural influences affect the rates of HIV infection among African Americans [16]. In 1999, nearly 1 in 4 African Americans were living in poverty [17]. Studies have found an association between higher AIDS incidence and lower income [18]. The socioeconomic problems associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, may directly or indirectly increase the risk factors for HIV infection.

PREVENTION

In the United States, the annual number of new HIV infections has decreased from a peak of more than 150,000 in the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Populations of minority races and ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced the Advancing HIV Prevention (AHP) initiative in 2003 (http://www.cdc.gov/hiv/topics/prev_prog/AHP/default.htm). This initiative comprises 4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing perinatal HIV transmission.

CDC has also established the African American HIV/AIDS Work Group to focus on the urgent issue of HIV/AIDS in African Americans. The work group developed a comprehensive response to guide CDC's efforts to increase and strengthen HIV/AIDS prevention and intervention activities directed toward African Americans. Already, CDC is engaged in a wide range of activities to involve community leaders in the African American community and to decrease the incidence of HIV/AIDS in African Americans.

For example, CDC

- Funds demonstration projects evaluating rapid HIV testing in historically black colleges and universities as well as projects to improve the effectiveness of HIV testing among African American women and MSM.
- Conducts epidemiologic research focused on African Americans, including
 - Brothers y Hermanos, a study of black and Latino MSM conducted in Los Angeles, New York, and Philadelphia that aims to identify and understand risk-promoting and risk-reducing sexual behaviors

- Women's Study, a study of black and Hispanic women in the southeastern United States that examines relationship dynamics and the cultural, psychosocial, and behavioral factors associated with HIV infection.
 - Addresses, through the Minority AIDS Initiative (<http://www.cdc.gov/programs/hiv08.htm>), the health disparities experienced in the communities of minority races and ethnicities at high risk for HIV infection. Funds are used to address the high-priority HIV prevention needs in such communities, including funding community-based organizations (CBOs) to provide services to African Americans. Examples of the programs that CBOs carry out are
 - A program in Washington, DC, that provides information to, and conducts HIV prevention activities for, MSM who do not identify themselves as homosexual. The activities include a telephone help line; Internet resources; and a program in barbershops that includes risk-reduction workshops, condom distribution, and training barbers to be peer educators.
 - A program in Chicago that provides social support to help difficult-to-reach African American men reduce high-risk behaviors. This program also provides women at high risk for HIV infection with culturally appropriate, gender-specific prevention and risk-reduction messages.
 - A program in South Carolina that is focused on changing the behaviors of adolescents to reduce their risk of contracting HIV infection and other STDs.
 - Creates social marketing campaigns, including those focused on HIV testing, perinatal HIV transmission, and the reduction of HIV transmission to partners.
 - Disseminates scientifically based interventions, including
 - SISTA (Sisters Informing Sisters About Topics on AIDS), a social-skills training intervention in which peer facilitators help African American women at highest risk reduce their risky sexual behaviors.
 - Many Men, Many Voices (3MV), an STD/HIV prevention intervention for gay men of color that addresses cultural and social norms, sexual relationship dynamics, and the social influences of racism and homophobia.
 - POL (Popular Opinion Leader), which identifies, enlists, and trains key opinion leaders to encourage safer sexual norms and behaviors within their social networks. POL has been adapted for African American MSM and shown to be effective in that population.
 - Healthy Relationships, a small-group intervention for men and women living with HIV/AIDS.
 - WILLOW (Women Involved in Life Learning from Other Women), to be disseminated in 2007, is a small-group, skills-training intervention for women living with HIV. WILLOW enhances awareness of the risky behaviors associated with HIV transmission, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills in negotiating safer sex, and reinforces the benefits of consistent condom use. WILLOW also teaches women how to recognize healthy and unhealthy relationships, discusses the effect of abusive partners on safer sex, and provides information about local shelters for women in abusive relationships.
- CDC also supports research to create new interventions for African Americans and to test interventions that have proven successful with other populations for use with African Americans. Additionally, CDC funds agencies through ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) to adapt and evaluate effective interventions for use in

communities of color.

In addition, CDC

- Provides intramural training for researchers of minority races and ethnicities through a program called Research Fellowships on HIV Prevention in Communities of Color.
- Established the extramural Minority HIV/AIDS Research Initiative (MARI) in 2002 to create partnerships between CDC epidemiologists and researchers who are members of minority races and ethnicities and who work in communities of color. MARI funds epidemiologic and preventive studies of HIV in communities of color and encourages the career development of young investigators. CDC invests \$2 million per year in the program and since 2003 has funded 13 junior investigators at 12 sites across the country [19].

REFERENCES

1. LCWK2. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 10-year age groups, by race and sex: United States, 2003. Available at http://www.cdc.gov/nchs/data/dvs/lcwk2_2003.pdf. Accessed January 29, 2007.
2. CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Atlanta: US Department of Health and Human Services, CDC; 2006:1–54. Available at <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report>. Accessed January 28, 2007.
3. CDC. Racial/ethnic disparities in diagnoses of HIV/AIDS—33 states, 2001–2004. *MMWR* 2006;55:121–125.
4. Anderson JE, Chandra A, Mosher WD. *HIV Testing in the United States, 2002*. Hyattsville, Md: National Center for Health Statistics; 2005:1–32. Advance Data from Vital and Health Statistics, No. 363.
5. Millett GA, Peterson JL, Wolitski, RJ, Stall R. Greater risk for HIV infection of black men who have sex with men: a critical literature review. *American Journal of Public Health* 2006;96:1007–1019.
6. Hader SL, Smith DK, Moore JS, Holmberg SD. HIV infection in women in the United States: status at the millennium. *JAMA* 2001;285:1186–1192.
7. Millett G, Malebranche D, Mason B, Spikes P. Focusing “down low”: bisexual black men, HIV risk and heterosexual transmission. *Journal of the National Medical Association* 2005;97:52S–59S.
8. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation, and prevention. *American Psychologist* 1993;48:1035–1045.
9. Sharpe TT, Lee LM, Nakashima AK, Elam-Evans LD, Fleming P. Crack cocaine use and adherence to antiretroviral treatment among HIV-infected black women. *Journal of Community Health* 2004;29:117–127.
10. CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five US cities, June 2004–April 2005. *MMWR* 2005;54:597–601.
11. CDC. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta: US Department of Health and Human Services, CDC; November 2006. Available at <http://www.cdc.gov/std/stats/toc2005.htm>. Accessed January 28, 2007.

Understanding HIV and AIDS Data

AIDS surveillance: Through a uniform system, CDC receives reports of AIDS cases from all US states and dependent areas. Since the beginning of the epidemic, these data have been used to monitor trends because they are representative of all areas. The data are statistically adjusted for reporting delays and for the redistribution of cases initially reported without risk factors. As treatment has become more available, trends in new AIDS diagnoses no longer accurately represent trends in new HIV infections; these data now represent persons who are tested late in the course of HIV infection, who have limited access to care, or in whom treatment has failed.

HIV surveillance: Monitoring trends in the HIV epidemic today requires the collection of information on HIV cases that have not progressed to AIDS. Areas with requirements for confidential name-based HIV infection reporting use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 33 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming) have collected these data for at least 5 years, providing sufficient data to monitor HIV trends.

HIV/AIDS: This term is used to refer to 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection and a later diagnosis of AIDS, (3) concurrent diagnoses of HIV infection and AIDS.

12. Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3–17.
13. CDC. HIV/AIDS among racial/ethnic minority men who have sex with men—United States, 1989–1998. *MMWR* 2000;49:4–11.
14. CDC. HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation—six US cities, 1994–2000. *MMWR* 2003;52:81–85.
15. Hart T, Peterson J. Predictors of risky sexual behavior among young African American men who have sex with men. *American Journal of Public Health* 2004;94:1122–1123.
16. National Minority AIDS Council. African Americans, health disparities and HIV/AIDS: recommendations for confronting the epidemic in black America. November 2006. Available at http://www.nmac.org/public_policy/4616.cfm. Accessed January 31, 2007.
17. US Census Bureau. Poverty: 1999. Census 2000 Brief. May 2003. Available at <http://www.census.gov/prod/2003pubs/c2kbr-19.pdf>. Accessed January 28, 2007.
18. Diaz T, Chu SY, Buehler JW, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine* 1994;10:217–222.
19. Trubo R. CDC initiative targets HIV research gaps in black and Hispanic communities. *JAMA* 2004;292:2563–2564.

For more information . . .

CDC HIV/AIDS

<http://www.cdc.gov/hiv>
CDC HIV/AIDS resources

CDC-INFO

1-800-232-4636
Information about personal risk and where to get an HIV test

CDC National HIV Testing Resources

<http://www.hivtest.org>
Location of HIV testing sites

CDC National Prevention Information Network (NPIN)

1-800-458-5231
<http://www.cdcpin.org>
CDC resources, technical assistance, and publications

AIDSinfo

1-800-448-0440
<http://www.aidsinfo.nih.gov>
Resources on HIV/AIDS treatment and clinical trials