



HIV/AIDS among African Americans

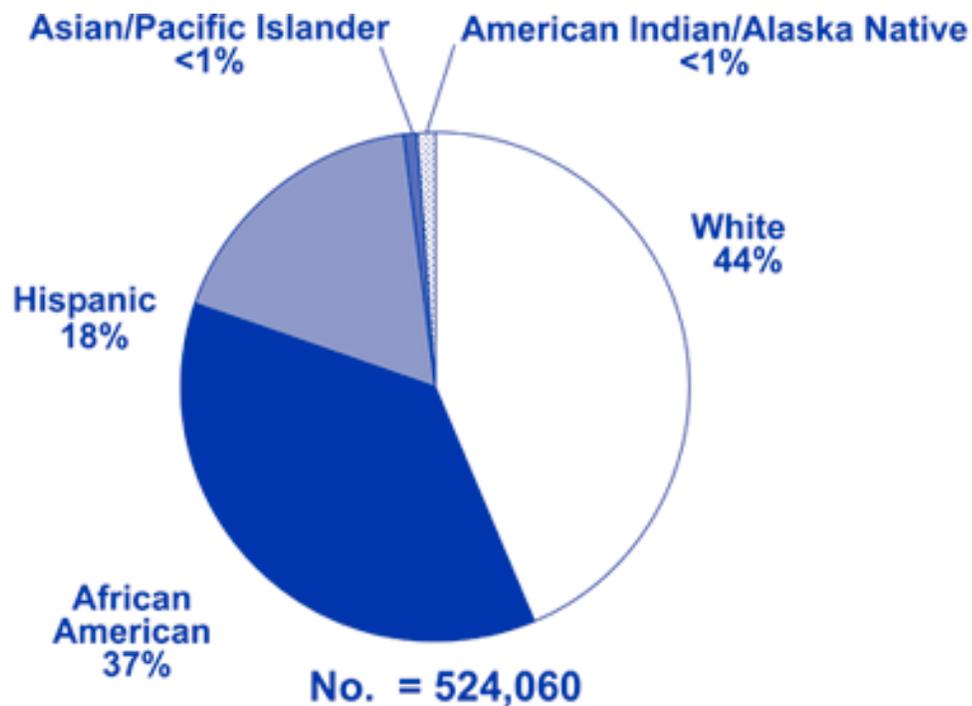
The HIV/AIDS epidemic is a health crisis for African Americans. In 2001, HIV/AIDS was among the top 3 causes of death for African American men aged 25–54 years and among the top 4 causes of death for African American women aged 20–54 years. It was the number 1 cause of death for African American women aged 25–34 years [\[1\]](#).

STATISTICS

Cumulative Effects of HIV/AIDS (through 2003)

- According to the 2000 Census, African Americans make up 12.3% of the US population. However, they have accounted for 368,169 (40%) of the 929,985 estimated AIDS cases diagnosed since the epidemic began [\[2\]](#).
- By the end of December 2003, an estimated 195,891 African Americans with AIDS had died [\[2\]](#).
- Of persons given a diagnosis of AIDS since 1995, a smaller proportion of African Americans (60%) were alive after 9 years compared with American Indians and Alaska Natives (64%), Hispanics (68%), whites (70%), and Asians and Pacific Islanders (77%) [\[2\]](#).
- During 2000–2003, HIV/AIDS rates for African American females were 19 times the rates for white females and 5 times the rates for Hispanic females; they also exceeded the rates for males of all races/ethnicities other than African Americans. Rates for African American males were 7 times those for white males and 3 times those for Hispanic males [\[3\]](#).

Race/ethnicity of persons who died with AIDS, 2003

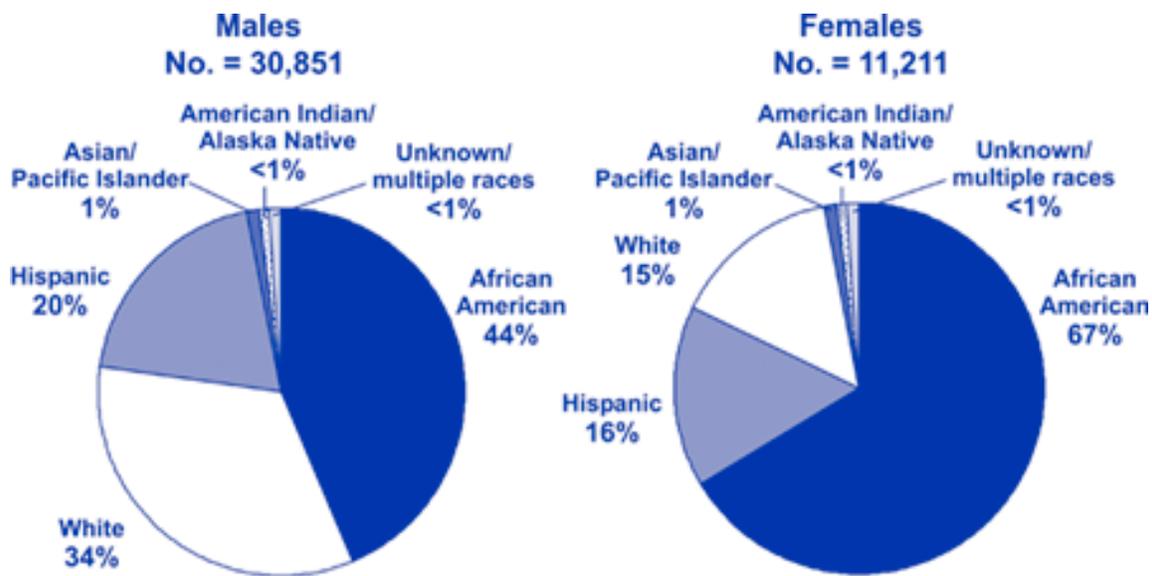


Note. Includes U.S. dependencies, possessions, and associated nations.

AIDS in 2003

- African Americans accounted for 21,304 (49%) of the 43,171 estimated AIDS cases diagnosed in the United States (including US dependencies, possessions, and associated nations) [2].
- The rate of AIDS diagnoses for African Americans was almost 10 times the rate for whites and almost 3 times the rate for Hispanics. The rate of AIDS diagnoses for African American women was 25 times the rate for white women. The rate of AIDS diagnoses for African American men was 8 times the rate for white men [2].
- In the United States, 172,278 African Americans were living with AIDS. They accounted for 42% of all people in the United States living with AIDS [2].
- Of the 59 US children younger than 13 years of age who had a new AIDS diagnosis, 40 were African American.

Race/ethnicity of persons given a diagnosis of AIDS, 2003

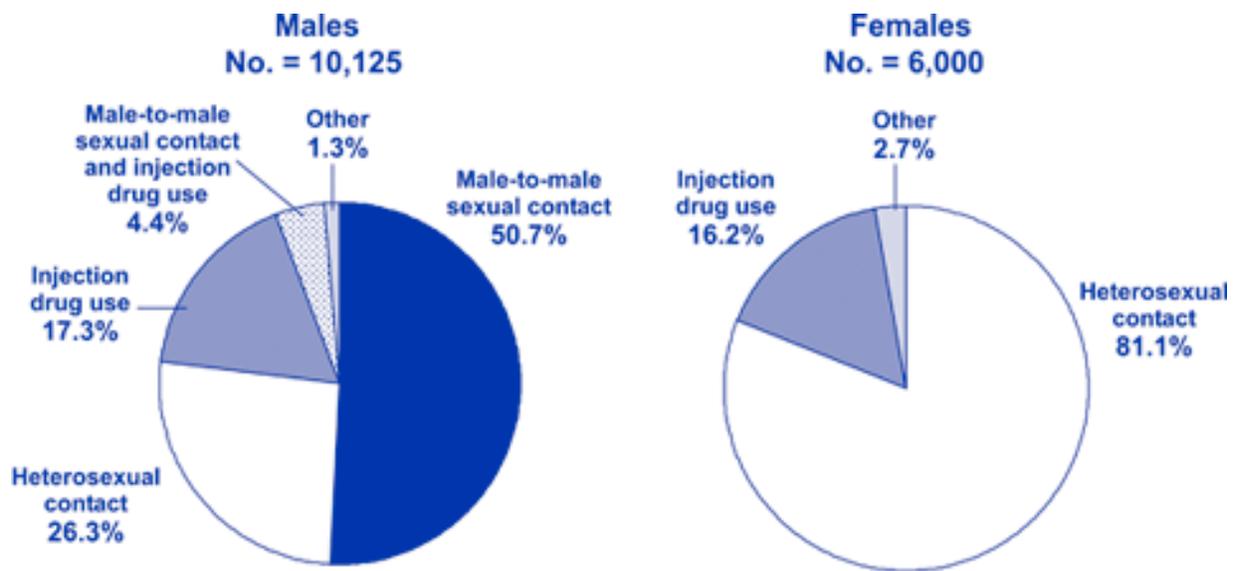


Note. Based on data from 50 states and the District of Columbia. Does not include US dependencies, possessions, and associated nations or persons whose state or area of residence is unknown.

HIV/AIDS in 2003

- African Americans accounted for 16,165 (50%) of the 32,048 estimated new HIV/AIDS diagnoses in the United States in the 32 states with confidential name-based HIV reporting [2].
- A study of people with a diagnosis of HIV infection found that 56% of late testers (that is, those who received an AIDS diagnosis within 1 year after their HIV diagnosis) were African American [4]. Late testing represents missed opportunities for preventing and treating HIV infection.
- The leading cause of HIV infection among African American men was sexual contact with other men; the next leading causes were heterosexual contact and injection drug use [2].
- The leading cause of HIV infection among African American women was heterosexual contact; the next leading cause was injection drug use [2].
- Of the 90 infants reported as having HIV/ AIDS, 62 were African American [2].

Transmission categories of African Americans given a diagnosis of HIV/AIDS, 2003



Note. Based on data from 32 states with confidential name-based HIV reporting.
Source. MMWR 2004; 53:1106-1110.

RISK FACTORS AND BARRIERS TO PREVENTION

Race and ethnicity are not, by themselves, risk factors for HIV infection. However, African Americans are more likely to face challenges associated with risk for HIV infection, including the following.

Partners at Risk

African American women are most likely to be infected with HIV as a result of sex with men [2]. They may not be aware of their male partners' possible risks for HIV infection such as unprotected sex with multiple partners, bisexuality, or injection drug use [5]. According to a recent study of HIV infected and noninfected African American men who have sex with men (MSM), approximately 20% of the study participants reported having had a female sex partner during the preceding 12 months [6]. In another study of HIV-infected persons, 34% of African American MSM reported having had sex with women, even though only 6% of African American women reported having had sex with a bisexual man [7].

Substance Use

Injection drug use is the 2nd leading cause of HIV infection for African American women and the 3rd leading cause of HIV infection for African American men [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 drug users were less likely than nonusers to take their antiretroviral medicines exactly as prescribed [9].

Sexually Transmitted Diseases

The highest rates of sexually transmitted diseases (STDs) are those for African Americans. In 2003,

African Americans were 20 times as likely as whites to have gonorrhea and 5.2 times as likely to have syphilis [10]. 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 by 3- to 5-fold. Similarly, a person who is coinfectd has a greater chance of spreading HIV to others [11].

Denial

Studies show that a significant number of African American MSM identify themselves as heterosexual [12,13]. As a result, they may not relate to prevention messages crafted for men who identify themselves as homosexual.

Socioeconomic Issues

Nearly 1 in 4 African Americans lives in poverty [14]. Studies have found an association between higher AIDS incidence and lower income [15,16]. The socioeconomic problems associated with poverty, including limited access to high-quality health care and HIV prevention education, directly or indirectly increase HIV risk. A recent study of HIV transmission among African American women in North Carolina found that women with HIV infection were more likely than noninfected women to be unemployed, receive public assistance, have had 20 or more lifetime sexual partners, have a lifetime history of genital herpes infection, have used crack or cocaine, or have traded sex for drugs, money, or shelter [16].

PREVENTION

Among all people in the United States, the annual number of new HIV infections has declined from a peak in the mid-1980s of more than 150,000 and stabilized since the late 1990s at approximately 40,000. Minority populations are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced a new initiative, Advancing HIV Prevention (<http://www.cdc.gov/hiv/partners/AHP.htm>), in 2003. 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.

The following are some CDC-funded prevention programs that state and local health departments and community-based organizations provide for African Americans.

- A program in Washington, DC provides information to, and conducts HIV prevention activities for, MSM who don't identify themselves as homosexual. The activities include a telephone help line; an Internet resource; and a program in barbershops that includes risk-reduction work shops, condom distribution, and the training of barbers to be peer educators.
- A program in Chicago provides social support to help difficult-to-reach African American men reduce high-risk behaviors. This program also provides high-risk women with culturally appropriate, gender-specific prevention and risk-reduction messages.

- A program in South Carolina focuses on changing behaviors in adolescents in ways that will reduce their risk of contracting HIV and other STDs.

CDC, through the Minority AIDS Initiative (<http://www.cdc.gov/programs/hiv09.htm>) ◀, also addresses the health disparities experienced in the communities of minority races/ethnicities at high risk for HIV. These funds are used to address the high-priority HIV prevention needs in such communities. CDC provides intramural training for minority researchers through a program called Research Fellowships on HIV Prevention in Communities of Color. Additionally, recognizing the importance of conducting culturally competent research and programs, CDC 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/ethnicities and who work in communities of color. MARI funds epidemiologic and preventive studies of HIV in minority communities 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 [17].

The following are examples of scientifically based interventions that CDC creates and provides to organizations.

- SISTA (Sisters Informing Sisters About Topics on AIDS) is a social-skills training intervention in which peer facilitators help African American women at highest risk reduce their HIV sexual risk behaviors.
- ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) provides funding to agencies to adapt and evaluate interventions shown to be effective in communities of color.

Understanding HIV and AIDS Data

AIDS surveillance: Through a uniform system, CDC receives reports of AIDS cases from all US states and territories. 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 collecting information on HIV cases that have not progressed to AIDS. Areas with confidential name-based HIV infection reporting requirements use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 33 areas—the US Virgin Islands and 32 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, 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 and to estimate risk behaviors for HIV infection. Recently, 9 additional areas have begun confidential name-based HIV surveillance, and data from these areas will be included

in coming years.

HIV/AIDS: This term includes persons with a diagnosis of HIV infection (not AIDS), a diagnosis of HIV infection and a later diagnosis of AIDS, or concurrent diagnoses of HIV infection and AIDS.

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