Understanding Disparities in the HIV Epidemic: How Social and Cultural Forces Lead to Unequal Risk for African Americans/Blacks

African Americans suffer from negative sexual health outcomes at greatly disproportionate rates, with young women and young men who have sex with men particularly at risk. A common misconception is that young African Americans simply are not as careful as whites in protecting their sexual and reproductive health. But a close examination of the extent of the HIV and STI epidemics and their underlying causes reveals a much more complex picture. In order to better combat the HIV and STI epidemics among young African Americans, it is necessary to examine how racism, poverty, incarceration, and other social factors have contributed to heightened risk.

Rates of HIV and STIs Among African Americans/Blacks Are Vastly Disproportionate to Population

- Nearly half a million people in the United States are living with HIV or AIDS. Although African Americans make up only about 13 percent of the population of the United States, almost half of those living with HIV or AIDS are African American.¹
- Racial disparities are especially pronounced among young people. Blacks comprise 69 percent of HIV positive youth ages 13-19, even though they make up only 17 percent of the population.²
- Young men of color who have sex with men are particularly at risk. Men who have sex with men accounted for sixty-five percent of all HIV diagnoses in 2004. And between 2001 and 2006, the number of HIV cases among men who have sex with men rose for all races, but there was a particularly sharp increase for young black men who have sex with men – 93 percent.³
- In 2004, young black women made up 71 percent of HIV infections among young women ages 13-24.⁴
- African Americans overall suffer Chlamydia rates eight times those of whites and gonorrhea rates 18 times as high. In 2006 young African American men ages 15-19 had thirty-nine times the gonorrhea rate of white men in the same age range. A recent study of STIs (sexually transmitted infections) among young women ages 15-19 found that 48 percent of African American women in this age range have an STI, compared to about 20 percent for white women.⁵

Even with Equal or Fewer Sexual Risk Behaviors, Blacks Are More At Risk

- Studies have shown that among men who have sex with men, black men are more at risk for HIV even when they have the same or fewer risk behaviors. An analysis of 53 studies found that black men were not more likely than whites to have unprotected anal sex, engage in commercial sex work, or have sex with a known HIV positive partner; and in fact reported having fewer partners than white men.⁶
- Research has shown that an individual black woman who has the same risk behaviors as a white woman is more likely to acquire an STI.⁷
- A study of over 14,000 young people ages 18-26 found that even when young African Americans and young whites had the same risk behaviors, African Americans were more likely to acquire HIV or STIs.⁸
How Does Examining Social Networks Expand Our Understanding of Disparities?

In HIV and STI research, a social network refers to a group of people who are connected sexually. These may be people who live in the same geographic area, but can also be very large, consisting of sub-communities within entire cities. The composition of one’s social network is an important contributing factor to one’s risk for HIV. Earlier epidemic research was conducted with the assumption of random contacts between all people; but this approach does not take into account the nature of and norms for sexual contact (which is typically not random), and creates a skewed understanding of the real risk for individuals. However, researchers now understand that an individual’s risk is not solely a result of personal risk behavior, but is also a function of the “pool” of disease in their sexual network.

Factors affecting the intensity of the HIV and STD epidemic within a given social network include:

- “Density,” or how many people within the network have had sexual contact with one another. In a very dense social network, with many people connected to many other people, an individual is much more likely to have contact with someone infected with HIV or an STI than a person in a social network where not many people have had sexual contact.
- How central to the network those with high-risk behaviors are – the more members of the network have sexual contact with high risk individuals, the higher the overall risk for members of the network.
- “Sorting” – This term describes the tendency of people with similar characteristics such as race or age to associate with one another and not with those outside the community. Sorting can be a protective factor for some social networks – if the members of a very low risk network make only sexual contacts within that network, their risk remains very low. However, sorting within a high-risk network leads to a much higher risk of infection for its members.
- Disease can be introduced into a formerly low-risk sexual network through a number of behaviors.
  - “Mixing” is when someone has sexual contact with someone outside their network. If the outsider has an STI, then the risk of the network rises. (One example of dissortative mixing is when young women have sex with older men, who are much more likely to be infected than young men.)
  - “Bridging” is when two existing social networks are joined through members having sexual contact with one another. This can heighten the risk for one or both networks.
  - “Concurrent partnerships” involve having more than one regular sexual partner at a time, which can put earlier partners at risk and contribute to higher network density. Concurrent partnerships can drastically increase the risk within a network by shortening the distance between an infected person and many non-infected persons.

Many African Americans are part of dense, highly-infected social networks, which means that when choosing a sexual partner, they are more likely to come into contact with an infected partner. This is why an individual African American has higher odds of being infected than an individual white person with the same or more risk behaviors.

What has led to the high infection rate within African Americans’ social networks?

Several linked issues contribute to higher infection rates within African Americans’ social networks and higher risk for African American youth – with racism being the most significant contributor. A history of oppression of African Americans dating back to slavery, and inequity that continues to the present, have led to a number of unfortunate realities which impact HIV risk for African American youth, especially those living in the Southern United States. Racism contributes to and is intertwined with underemployment and unemployment, decreased access to medical care, and incarceration. The chart following demonstrates the complicated relationships between the societal and cultural factors bolded in the paragraphs below.
Almost a quarter of African Americans are living in poverty, compared to 11 percent of whites. Those who live in poverty are more likely to commit crime, especially drug-related crime. They are more likely to live in unstable neighborhoods with higher rates of crime and more liquor stores. Poverty also contributes to problem alcohol use, which in turn contributes to unemployment/underemployment and unstable relationships. Unstable relationships can lead to unprotected sex if partners are afraid that insisting on condoms will endanger the relationship.

Those living in poverty are also less likely to have access to medical treatment – meaning they may go for long periods of time either unaware they are infected with HIV or an STI, or without treatment for it. For instance, HIV positive black men who have sex with men are less likely than HIV positive white men to be taking ART (anti-retroviral therapy, a group of HIV medications). Because treatment for HIV decreases the viral load, those who are not receiving treatment are more likely to transmit HIV. In addition, because one aspect of historical oppression includes abuses of African Americans by the medical community (such as the Tuskegee syphilis experiment, where doctors allowed black men to go without a cure to see how the disease progressed), African Americans may also mistrust the medical system, which can in turn lead to delayed diagnosis and treatment.

Stricter sentencing laws around drug-related crime have resulted in the incarceration of millions of African Americans, especially African American men. More than one in four are incarcerated during their lifetime. Certainly, unprotected sex in prison is one way HIV can be transmitted – men in prison have less sex overall but more risky sex than men who are not incarcerated. But another effect of imprisonment is to render unstable the relationships between incarcerated men and their long-term partners or wives, leading to concurrent partnerships.
In addition to the issues originating in racism and oppression for African Americans, social stigma around homosexuality contributes to health disparities. Men who are secretive about homosexual behavior may have lowered access to medical treatment – they may be less likely to seek treatment and may be diagnosed later than those who are openly gay. Studies have shown some African American men may also have sex with both men and women but not disclose their sexual relationships with men – a different kind of concurrent partnership that can still put their female partners in danger.11

The result of all of these factors combined is that HIV and STI rates are higher in the pool of partners African Americans are likely to choose from, putting them more at risk.

Strategies for Redressing Disparities

Researchers have identified ways in which programs and policies might work toward eliminating disparities and lowering HIV and STI rates among African Americans, including building on assets African American youth have already demonstrated they possess.

- **Promote reproductive justice.** Reproductive justice is defined as the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women’s human rights.15

- **Support structural interventions** which seek to address or influence social, political and/or economic environments to redress disparities in HIV. Examples include, but are not limited to:
  - condom availability programs and comprehensive sex education in schools
  - population education - educational techniques designed to raise the consciousness of its participants and allow them to become more aware of how an individual’s personal experiences are connected to larger societal problems
  - harm reduction – needle exchange legislation and programs for injection drug users
  - microfinancing - programs that seek to reduce women’s vulnerability to HIV by bolstering their economic prospects. One study, a pilot project in Baltimore, MD examined the efficacy of economic empowerment and HIV prevention among women who used drugs and were involved in prostitution. This study demonstrated significant reductions in receiving drugs or money for sex, the median number of sex trade partners per month, daily drug use and the amount of money spent on drugs each day16
  - community mobilization
  - ensuring access to quality education and health care

- **Utilize peer influence within social networks.** Research on social networks has found that they include certain peer leaders – members who can influence the behavior of others in the network. Programs can use this influence to affect behaviors that reduce transmission rates, including:
  - **HIV testing.** Programs in which community members recruit friends and acquaintances to be tested for HIV have been found to increase HIV testing rates and even reduce risk behaviors.17,18 Earlier diagnosis of and treatment for HIV is essential to reducing viral levels.
  - **Condom use.** Studies have shown that adolescents who believe their peers are using condoms are also more than twice as likely to use condoms compared to teens who do not believe their peers use condoms.19,20 Conversely, one recent study specifically of young African American men who have sex with men found that men at high risk for HIV were less likely to say their friends approved of condom use. Research has shown that African American youth of both sexes were more likely to use condoms at last intercourse than youth of any other race.21 Programs can build on young African Americans' proven self-efficacy for condom use by teaching all young people about condoms, normalizing condom use as an effective means of preventing HIV and other STIs, encouraging youth to communicate openly about condoms with peers and partners, and making sure condoms and information about condoms are available.
Promote partner reduction and monogamy. African American youth are much more likely to report having had four or more partners as white students, and almost four times as likely to report having had sex before the age of 13 as white students. Because concurrent partnerships can greatly increase the “pool” of sexually transmitted infections in one’s social network, it is important for programs to teach youth about the risks associated with having multiple partners, teach the benefits of abstinence and monogamy, and to stress the importance of condom use at every act of intercourse.

Tailor programs to communities served. Researchers have identified cultural competency as an important element in creating programs for racial and sexual minority youth. Program planners should identify one of the evaluated sexual health programs which takes into account the heritage, community, and social norms of African American youth and which provide them relevant information in a culturally competent manner.

Conclusion

In addition to promoting personal behaviors that protect individuals from risk, social inequities, especially those that negatively affect the health of young African Americans or even threaten their lives, must be eliminated. Vaccine research must continue to be funded. Adequate health care and access to condoms and contraception must be made available to all youth. Health care systems should offer culturally competent health care and study how best to serve African American communities. Activists, educators, and youth-serving professionals should educate themselves about HIV and STI rates and the root causes of the disparities among races.

References

13 Thomas JC. “From slavery to incarceration: social forces affecting the epidemiology of sexually transmitted diseases in the rural South.” Sexually Transmitted Diseases 2006; 33 (7 Suppl): s6-10.


Written by Jennifer Augustine, MPH and Emily Bridges, MLS

Advocates for Youth © 2008