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Heterosexual Risk for HIV Among Black Men in the United States: A Call to Action Against a Neglected Crisis in Black Communities

Anita Raj, PhD¹ and Lisa Bowleg, PhD²

¹University of California, San Diego, San Diego, CA, USA

²Drexel University, Philadelphia, PA, USA

Abstract

Recent data from the Centers for Disease Control and Prevention demonstrate that 1 in 16 Black men in the United States will be infected with HIV in their lifetime. Furthermore, the long-standing HIV disparity in Black communities is actually increasing for Black men. National efforts to curb the epidemic among U.S. Black men focus primarily on men who have sex with men and injection drug users. Black men at heterosexual risk for HIV have largely been neglected by research, program, and policy. This article presents epidemiologic data documenting that heterosexual risk for HIV among Black men is a major concern for Black communities and is likely additional evidence among growing indications of a generalized epidemic in low-income and urban Black communities. The authors offer a call to action to increase support for research, program, and policies that can improve HIV prevention and testing among heterosexual Black men in the United States, as part of the national agenda to reduce rates of HIV in Black communities.

Keywords

HIV/AIDS; physiological and endocrine disorders; public health; health care issues

HIV continues to disproportionately affect Black communities in the United States, with more than half of all new HIV cases occurring among Black adults (Centers for Disease Control and Prevention [CDC], 2010a, 2011). This health disparity is increasing, such that 1 in 16 Black men is projected to become infected with HIV in their lifetime (Hall, An, Hutchinson, & Sansom, 2008). Nationally, men who have sex with men (MSM) remain at greatest risk for infection (CDC, 2010a, 2011); however, the most recent HIV surveillance data from the northeastern United States (e.g., Massachusetts, Pennsylvania, Washington DC—see state and city HIV surveillance reports with data from 2008-2009) document heterosexual transmission as the primary means of HIV infection for Black men. Heterosexual transmission accounts for 87% of new HIV infections for Black women, who are assumed to predominantly have Black male partners (CDC, 2010a).

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Corresponding Author: Anita Raj, Division of Global Public Health, School of Medicine, University of California, San Diego, 9500 Gilman Drive, MC 0507, La Jolla, CA 92093, USA, anitaraj@ucsd.edu.

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Trends of increasing proportions of Black men acquiring HIV heterosexually in the United States (CDC, 2010a) suggest that data from the northeast may be a harbinger of what we will see nationally, in terms of primary means of HIV exposure for U.S. Black men. These findings suggest that Black communities may be moving toward a more generalized HIV epidemic, approaching an HIV rate of 1% and predominantly acquiring HIV via heterosexual sex. Recent research documenting indications of a generalized epidemic in low-income urban Black communities (Denning & DiNenno, 2010) support the need for a generalized HIV prevention response for Black communities, where all classes of individuals rather than just those “most at risk” are reached.

National policy efforts, including the CDC’s (2009b) *Heightened National Response to the HIV/AIDS Crisis Among African Americans* and the President’s *National HIV/AIDS Strategy* (Office of National AIDS Policy, 2010), recognize the need for a generalized epidemic response for Black communities but to a limited degree. Both of these documents highlight the need for community-level approaches to HIV prevention and services and recommend targeted approaches to reach MSM, women, and youth, but do not highlight focus on heterosexual Black men. In part, this may be because of the lack of effective intervention models for Black men at heterosexual risk for HIV. Although there are a number of community-based HIV interventions with demonstrated effectiveness with Black MSM, women, and youth, such effective interventions remain lacking for heterosexual Black men (CDC, 2009a). Heterosexual Black men remain neglected in HIV program, policy, and research in the United States despite growing epidemiologic data attesting to their needs.

Lack of focus on heterosexual Black men is likely attributable to the ongoing assumption that Black men acquire HIV via same sex behavior, and heterosexual HIV risk for Black women is because of the “down low” among Black men (Aral, Adimora, & Fenton, 2008). The “down low” is a situation in which male partners concurrently have sex with women and men, without their female partner’s knowledge, acquiring HIV from the male partner and transmitting it to the female. However, research documents this to be a myth, as the number of men engaging in “down low” behavior is too few to explain current HIV rates among Black women; risk is now attributed to men’s injection drug use and concurrent heterosexual sex partnering (Aral et al., 2008). However, again, injection drug use–related transmission is less common than heterosexual risk (CDC, 2010a, 2011), leaving heterosexual exposure the most likely means of infection for these men.

Confusing the matter, however, is the fact that there is far greater physiologic efficiency of male to female, rather than female to male, HIV transmission. Despite this physiologic reality, heterosexual exposure is the means by which HIV infection occurs among one in seven newly HIV-infected men in the United States; 71% of these men are Black (CDC, 2010a). High incidence and prevalence of sexually transmitted infections (STIs) among Blacks is a likely explanation as to why such female to male transmission is affecting Black communities and to a greater degree than that seen for other racial/ethnic groups (CDC, 2010b). Comorbid STIs increase patients’ susceptibility to HIV acquisition and transmission two- to fivefold. STIs increase the likelihood of HIV acquisition if the uninfected individual has genital ulcers through which the virus can enter. Susceptibility also increases in the presence of genital inflammation, which increases the number of cells in genital secretions that can be targeted by HIV. STIs can also increase the likelihood of HIV transmission because HIV-infected individuals with STIs (e.g., herpes, gonorrhea) appear to shed higher concentrations of HIV in their genital secretions relative to HIV-infected individuals with no STIs.

Recent STI surveillance documents disproportionate rates of bacterial and viral STIs among both Black men and women (see Table 1). Although Blacks represent 12% of the U.S.

population, Black males represent 49% of syphilis cases, 53% of chlamydia cases, and 73% of gonorrhea cases among males, based on 2009 CDC (2010b) surveillance reports. Similar disparities are observed for Black females (CDC, 2010b). Additionally, 40% of Blacks as compared with 20% of Whites are herpes positive, and among 40- to 49-year-olds, 60% of Blacks are herpes positive (CDC, 2010b). (Sex-specific data on herpes unavailable.) Among Black males and females, as with other racial/ethnic groups, STIs disproportionately affect those aged 15 to 24 years (CDC, 2010b). HIV also affects Blacks at younger ages. Blacks between 20 and 24 years old have the highest rates of HIV. By comparison, the highest rates of HIV occur among Whites and Latinos in the 25- to 49-year age group (CDC, 2010a). Overall, these epidemiologic data point to the heavy burden STIs place on Black communities and the likely role they play in increasing heterosexual risk for HIV among Black men, as well as in lowering age of infection, and thus increasing opportunity for lifetime transmission, within Black communities.

Disproportionate rates of HIV and STI in low-income, urban, and predominantly Black communities clearly help drive Black men's heightened risk for heterosexually acquired HIV and a generalized HIV epidemic in Black communities (CDC, 2010a, 2010b). Corresponding with these findings, poverty, substance use, high incarceration rates, and resultant unstable housing and employment contribute to ongoing sex risk (e.g., concurrent sexual partnering, sex trade involvement, unprotected sex) and HIV and STI among Black men (Aral et al., 2008). These findings document the need for intervention approaches that do not simply make available condoms and HIV education for heterosexual Black men but also alter structural risk factors that maintain high rates of HIV and STI in their neighborhoods and their lives. Such structural intervention efforts may include employment and housing programs, community development efforts, and policy changes to reduce these men's vulnerabilities to incarceration.

As we build a new national agenda to address HIV in Black communities, we must recognize and address the increased risks that Black men face because of heterosexual exposure and high rates of STI. This recognition should build on the science, not the assumption that heterosexual Black men are not at risk for HIV. If we as researchers and practitioners fail to recognize and address heterosexual risk for HIV among Black men, why should we expect Black heterosexual men to do so? And in the absence of that change, growing HIV disparities for Black men will continue and the risk for a generalized epidemic in Black communities will grow. Hence, we offer the following recommendations for research, program, and policy to address HIV risk in Black communities generally via increased focus on Black men at heterosexual risk for HIV:

1. Programmatically focused research is needed toward the development and evaluation of community-based interventions to promote HIV prevention and to increase HIV counseling and testing utilization for Black men at heterosexual risk for HIV. Such programming would best be offered (a) in venues in which Black men already frequent (e.g., barber shops, job training programs) as standard clinical sites are less likely to reach this population, (b) via messaging from heterosexual Black men within the community to give greater credibility to the reality of HIV risk for heterosexual men, and (c) with linkages between community organizations serving HIV needs of Black communities (e.g., HIV counseling and testing programs) and community organizations serving the social and welfare services (e.g., job placement programs, public housing programs) that affect structural factors that heighten HIV risk for Black men.
2. Organizational funding for community-based programming is important to ensure that programs can be developed and maintained in the community, once effective models of intervention for heterosexual Black men at risk for HIV are identified.

Certainly, important government efforts such as the Minority AIDS Initiative must continue to receive government funding and recognition. However, given the current economic climate, we cannot solely look to state and federal government to provide financial support for these efforts. Rather we must expand considerations to public–private partnerships, a common approach in developing world settings, such that private funding can be used with public dollars to provide sustainable programming for vulnerable populations (AIDS.gov, 2010).

3. Policy efforts must shift to be more supportive of Black men in impoverished urban settings, the locale for the majority of HIV-infected heterosexual Black men in the United States (CDC, 2010a). Urban Black neighborhoods are too often characterized by poverty, low-performing schools, inadequate job opportunity, and high rates of violence and illicit drug trade, inciting many young men to turn to illicit activity for survival and increasing their risk for incarceration (Mincy, 2006). Policy changes have the capacity to address structural risks for HIV (e.g., unemployment, homelessness, incarceration history among Black men) that health programs cannot achieve. Sadly, current policies more often restrict access to housing and employment postincarceration, contributing to destabilized lives and relationships, as well as increased risk for HIV/STI, for these young men (Mincy, 2006; Raj et al., 2008). Reversals of these policies could facilitate increased stabilization of employment and housing for heterosexual Black men and potentially reduce their risk HIV/STI. Importantly, such an approach benefits Black women and Black MSM, as well, as they too cannot be forgotten.

It has now been 30 years since the first cases of HIV were recognized as a potential epidemic for this country. Thirty years ago, U.S. government and society were slow to respond, in no small part to the lack of value we placed on the lives of gay men. Let us not repeat history by continuing to ignore the heterosexual HIV epidemic Black men are facing in the United States, an occurrence likely, for similar reasons, gay men experienced. Research, programmatic work, and policies must be inclusive of heterosexual Black men and approaches to address structural risk factors for HIV in this population, if we are truly to affect the continuing HIV disparity in Black communities.

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Table 1

HIV and Bacterial STI Rates per 100,000 Population for Blacks Versus All Races, by Gender

	Male cases		Female cases	
	Black males	All males	Black females	All females
HIV	131.9	35.9	56.0	11.5
Chlamydia	970.0	219.3	2095.5	592.2
Gonorrhea	555.2	91.9	557.5	105.5
Primary and secondary syphilis	31.3	7.8	8.2	1.4

Note. Data taken from Centers for Disease Control and Prevention's (CDC) HIV surveillance report (CDC, 2010a) and STI surveillance report (CDC, 2010b). STI = sexually transmitted infection.