What are Black Men's HIV Prevention Needs?

UCSF Center for AIDS Prevention Studies
Prevention Research Center
Division of Prevention Science

Prepared by Bob Haas & Barbara Green-Ajufo, DrPH, MPH

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Who are black men?

In the U.S., Black men include different ethnic groups from the African Diaspora. They are friends and diverse family members: fathers, grandfathers, husbands, partners, brothers, uncles, sons, nephews, and cousins. They are colleagues working in professional and blue-collar jobs. They also represent different sexual orientations, have diverse spiritual and religious beliefs, and speak different languages, among having other demographic differences.

Why is HIV a concern among black men?

HIV is a health emergency among Black men of every age and sexual orientation. In 2015, 33% of HIV infections diagnosed in the U.S. were among Black men. They were diagnosed eight times more than white men and two times more than Hispanic men.[1] One in every twenty Black men will be diagnosed with HIV in their lifetime. Among the general population of men, Black men have a higher risk of HIV, noted by the differences below that will continue if current trends are not reversed.[2-4]

- Men who have sex with men (MSM): black (1 in 2); general MSM population (1 in 6)
- Injection drug users (IDU): black men (1 in 9); general male IDU population (1 in 36)
- Heterosexual men: black (1 in 86); general heterosexual male population (1 in 473)

Among MSM, Black MSM (BMSM) – including gay and bisexual men – are more likely than others to be diagnosed with HIV (39% in 2015).[5] Young Black MSM (YBMSM) are most at risk. Seventy-five percent of all BMSM diagnosed with HIV in 2015 were ≤ age 34 – split equally between those aged 13-24 (37.7%) and aged 25-34 (37.3%).[6]

Many studies have shown that BMSM's engagement in unprotected "condomless" anal intercourse (UAI) and number of sexual partners are similar to or less than MSM of other race or ethnic groups. However, BMSM are more likely to be diagnosed with HIV. This finding is true for different populations of BMSM.[7-10] In one study, YBMSM were nine times more likely to be living with HIV than white participants with similar risks.[7]

The demand for and awareness of PrEP – a proven biomedical intervention – is lower for BMSM than white MSM (WMSM).[11] From January 2012 to September 2015, 74% of the PrEP prescriptions in the U.S. were to whites, 12% to Latinos, and 10% to African Americans.[12]

What are HIV risk factors for black men?

Many factors affect Black men's risk of HIV infection.

Stigma and Discrimination – When Black men experience stigma or discrimination, they are less likely to use PrEP [13] or disclose their HIV status.[14] Moreover, discrimination-related traumas, based on being gay, black or living with HIV, are associated with greater UAI.[15] High HIV infection rates, racist attitudes of non-Black gay men, and social networks and environments where gay men gather have been found to stigmatize and isolate BMSM from other MSM.[16]

HIV Care Continuum Disparities – Poor retention of Black men in health care is deeply rooted in discriminatory practices of the medical system towards the Black community.[17] Consequently, BMSM are less likely than WMSM to know their HIV status, more likely to be diagnosed later, and less likely to stay engaged in care and on treatment.[18-19]

Poverty – Discrimination and reduced access to and retention in quality education are reasons that Black men experience more unemployment or are underemployed, compared to white men.[20] Consequently, Black men are more likely to be living in poverty, which usually means reduced access to quality health care.[20] HIV rate increases 3.0 to 5.5 times with increasing neighborhood poverty level from < 10% (low poverty) to more than 30% (very high poverty level).[21-22] For Black individuals living with HIV, poverty is associated with lower levels of engagement in HIV care.[23]

Sexual Trauma – Sexual abuse and assault rates are high among MSM and are related to greater risks of HIV infection. In the EXPLORE Study, 39% of MSM reported childhood sexual assault; Black participants were more likely to have a history of assault than no history of assault.[24-25]

Sexually Transmitted Diseases (STDs) – Having an STD can increase the chances of a person transmitting or becoming infected with HIV.[26] STD and HIV disparities in the Black community increase the likelihood of HIV transmission.[27-29]

Social networks and sex with men of their race – The high HIV rate among BMSM and their preference for sex with MSM of their same race increase the chances of BMSM having a sexual partner that is living with HIV. A review of studies found that at least 29% of BMSM in networks having sexual contact were living with HIV and 47% of men living with HIV in these networks did not know their status.[30]

What is being done?

Research findings for black men of diverse ages, sexual orientations, and HIV serostatus, discussed below, have been shown to reduce sexual risk behaviors and increase engagement in HIV care.[31]

Randomized Comparison Group Interventions: Two studies, Many Men Many Voices (3MV) and Brothers to Brothers, report positive findings for either a reduction in number of UAI occurrences with casual partners, number of any unprotected insertive anal intercourse, number of male sex partners, and/or a greater likelihood to test for HIV.

Pre- Post-Test/Repeated Survey Interventions: Black MSM who participated in D-up! Connect with Pride, BRUTHAS, Motivational Interviewing (MI), or Special Projects of National Significance (SPNS) interventions report improved outcomes, compared to those with limited or no participation. Studies found either a reduction in any UAI at different times during the intervention, a reduction in occurrences of UAI with main partners, reduced number of sexual partners, greater condom use with main partners, reduced number of high-risk sexual encounters with female sex partners, and/or a reduction in sex under the influence of drugs. Different studies also reported improvements in social support, self-esteem, and loneliness, as well as improved likelihood of HIV counseling and testing, return for test results, and fewer missed HIV medical visits. For one study, as the number of hours spent attending case management meetings increased, the time in HIV care increased.

Blended Pre- Post-Test and Control Group: Young MSM of color who participated in STYLE (Strength Through Youth Livin' Empowered) reported 83% retention in care, and the chances of attending a clinic visit was greater for the STYLE participants than non-participants (2.58, 95% CI 1.34-4.98).

What still needs to be done?

HIV prevention targeting Black men should not simply address high-risk sexual behaviors but also societal and structural issues. We need policies that will prevent new infections and add to our understanding of Black/White HIV infection disparities, including the role of structural interventions. [32-33]. We need to combine behavioral and biomedical interventions; abandon a "one size fits all" approach; address high STD rates, traumatic events and structural and access barriers; and, consider the intersection of health and social conditions.

The need to address stigma – including ones that are unapparent – must not be lost. For example, data must be presented with background, community perspective, and accurate explanation. HIV disclosure must include strategies to help partners and family members receive information that their loved one is gay or living with HIV. Broad implementation of successful interventions in areas where HIV is highest for Black men is necessary.

Says who?

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