HIV/AIDS among Hispanics

The HIV/AIDS epidemic is a serious threat to the Hispanic community. In addition to being a population seriously affected by HIV, Hispanics continue to face challenges in accessing health care, prevention services, and treatment. In 2001, HIV/AIDS was the third leading cause of death among Hispanic men aged 35 to 44 and the fourth leading cause of death among Hispanic women in the same age group [1].

STATISTICS

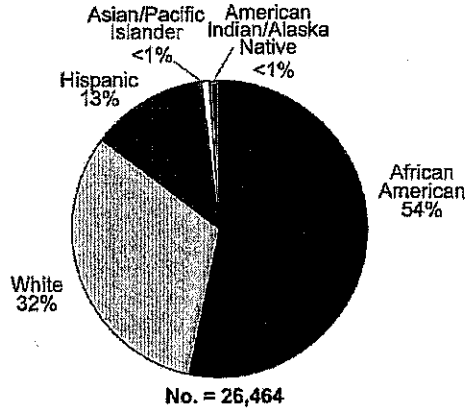
Cumulative Effects of HIV Infection and AIDS (through 2002)

- Although Hispanics made up only about 14% of the population of the United States and Puerto Rico [2,3], they accounted for 18%—almost 164,000—of the more than 886,500 AIDS cases diagnosed since the beginning of the epidemic [4]. By the end of 2002, nearly 88,000 Hispanics had died with AIDS [4].
- Among people given a diagnosis of AIDS since 1994, a smaller proportion of Hispanics (61%), compared with whites (64%) and Asians and Pacific Islanders (69%), were alive after 9 years. However, the proportion of surviving Hispanics was larger than the proportions of surviving American Indians and Alaska Natives (58%) and African Americans (55%) [4].

AIDS in 2002

- Hispanics accounted for more than 8,000, or 20%, of the more than 42,000 new AIDS diagnoses in the United States [4].
- Of the rates of AIDS diagnoses for all racial and ethnic groups, the second highest was the rate for Hispanics. The highest rate was that for African Americans (76.4 cases per 100,000 people), followed by the rates for Hispanics (26.0/100,000), American Indians and Alaska Natives (11.2/100,000), whites (7.0/100,000), and Asians and Pacific Islanders (4.9/100,000) [4].
- The 76,052 Hispanics living with AIDS accounted for 20% of all people in the United States living with AIDS [4].

Estimated cases of HIV/AIDS diagnosed in 2002 by race

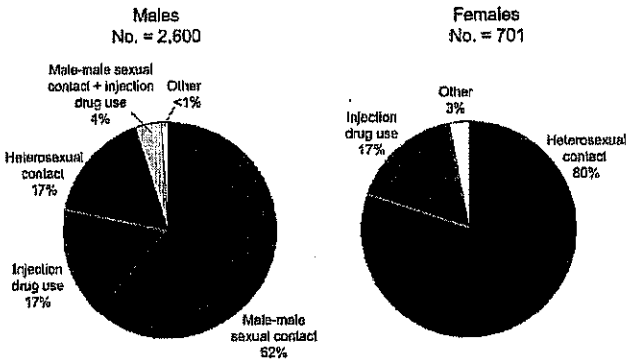


Note. Based on data from 30 areas with confidential name-based HIV reporting.

HIV/AIDS in 2002

- Hispanics accounted for 13% of new HIV/AIDS diagnoses reported in the 30 areas with long-term, confidential name-based HIV reporting in the United States [4].
- From 1999 through 2002, the number of new HIV/AIDS diagnoses increased 26% among Hispanics in the 30 areas [4].
- Most Hispanic men are exposed to HIV through sexual contact with other men, followed by injection drug use and heterosexual contact. Most Hispanic women are exposed to HIV through heterosexual contact, followed by injection drug use [4].

Estimated cases of HIV/AIDS diagnosed in 2002 among Hispanic adults and adolescents



Note. Based on data from 30 areas with confidential name-based HIV reporting.

RISK FACTORS AND BARRIERS TO PREVENTION

A number of cultural, socioeconomic, and health-related factors help drive the HIV epidemic in the Hispanic community. Because Hispanic Americans or their parents have emigrated from many Latin countries or regions, there is no single Hispanic culture in the United States. Research shows that Hispanics born in different countries have different behavioral risk factors for HIV/AIDS. For example, data suggest that Hispanics born in Puerto Rico are more likely than other Hispanics to contract HIV as a result of injection drug use. By contrast, sexual contact with other men is the primary cause of HIV infections among men born in Mexico [4].

Cases of AIDS diagnosed in the United States by exposure category in 2002 among Hispanics born in different countries

	United States %	Central/ South America %	Cuba %	Mexico %	Puerto Rico %
Male-male sexual contact	39	52	50	57	17
Injection drug use	29	11	24	13	45
Male-male sexual contact + injection drug use	4	2	5	4	3
Heterosexual contact	27	33	21	24	34
Other	1	2	1	2	0

Other risk factors and barriers to prevention include the following.

Poverty

More than 1 in 5 (22.6%) Hispanics lives in poverty [5]. Of the Hispanic people with HIV/AIDS interviewed in a multisite study, 47% of Mexican-born men who have sex with men (MSM) and 59% of Puerto Rican–born MSM had annual incomes of less than $10,000 [6]. A variety of socioeconomic problems associated with poverty, including limited access to high-quality health care, directly or indirectly increase the risk for HIV infection.

Denial

Although many Hispanics are increasingly engaged in the fight against HIV/AIDS, some Hispanic communities have been slow to join the effort. In part because of cultural values such as machismo (sense of manliness), communities may be reluctant to acknowledge sensitive yet risky behaviors, such as homosexuality [7]. Many Hispanic MSM identify themselves as heterosexual and, as a result, may not relate to prevention messages crafted for gay men [8].

Heterosexual Risk

Hispanic women are most likely to be infected with HIV as a result of sex with men [4]. In a study of heterosexual Hispanics living in the United States, 16% had sexual risk factors for HIV, including multiple sex partners or high-risk main partners [9]. Some women, including those who suspect that their partners are at risk for HIV infection, may be reluctant to discuss condom use with their partners out of fear of emotional or physical abuse or the withdrawal of financial support [10].

Substance Abuse

Injection drug use continues to be a significant risk factor for Hispanics. Sharing needles is not the only HIV risk factor related to substance abuse. Both 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 [11].

Sexually Transmitted Diseases

Compared with whites, Hispanics are about twice as likely to have gonorrhea or syphilis [12]. Sexually transmitted infections increase the likelihood of HIV transmission [13].

PREVENTION

The annual number of new HIV infections among all people in the United States declined from a peak of more than 150,000 cases in the mid-1980s and has stabilized at approximately 40,000 cases since the late 1990s. 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.

In the United States, Hispanics are emerging as an at-risk group. CDC is conducting demonstration projects on using social networks to reach high-risk persons in communities of color. CDC's Minority AIDS Initiative (http://www.cdc.gov/programs/hiv09.htm) explores the disparities in minority communities at high risk for HIV and what can be done to reduce these disparities.

Examples of CDC-funded programs focused on Hispanics include a community-based free health clinic offering bilingual, bicultural HIV/AIDS programs in Washington, DC; one-on-one interventions for transgender people in various California urban areas; and a food bank in East Los Angeles that serves persons living with HIV/AIDS.

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. 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 30 areas—the US Virgin Islands and 29 states (Alabama, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, 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.

REFERENCES

1. Anderson RN, Smith BL. Deaths: leading causes for 2001. National Vital Statistics Report 2003;52(9):51,53. Available at http:// www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_09.pdf. Accessed October 26, 2004.
2. US Census Bureau. Annual estimates of the population by sex, race and Hispanic or Latino origin for the United States: April 1, 2000–July 1, 2003. Available at http://www.census.gov/popest/national/asrh/NC-EST2003/NC-EST2003-04-12.pdf. Accessed August 30, 2004.
3. Annual estimates of the population for the United States and States, and for Puerto Rico: April 1, 2000–July 1, 2003. Available at http://www.census.gov/popest/states/NST-EST2003-ann-est.html. Accessed August 30, 2004.
4. CDC. HIV/AIDS Surveillance Report 2002;14: 1–40. Also available at http://www.cdc.gov/hiv/stats/hasrlink.htm. Accessed July 26, 2004.
5. US Census Bureau. Poverty 1999: Census 2000 Brief. Issued May 2003. Available at http://www.census.gov/prod/2003pubs/c2kbr-19.pdf. Accessed August 30, 2004.
6. Diaz T, Chu S, Buehler J, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. American Journal of Preventive Medicine 1994;10:217–222.
7. Diaz R. Latino gay men and psycho-cultural barriers to AIDS prevention. In: Levin MP, Nardi PM, Gagnon JH, eds. In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS. Chicago: University of Chicago Press; 1997.

8. CDC. HIV/AIDS among racial/ethnic minority men who have sex with men—United States, 1989–1998. MMWR 2000;49:4–11.

9. Sabogal F, Catania JA. HIV risk factors, condom use, and HIV antibody testing among heterosexual Hispanics: the National AIDS Behavioral Surveys (NABS). Hispanic Journal of Behavioral Sciences 1996;18: 367–391.

10. Suarez-Al-Adam M, Raffaelli M, O'Leary A. Influence of abuse and partner hypermasculinity on the sexual behavior of Latinas. AIDS Education and Prevention 2000;12:263–274.

11. Leigh B, Stall R. Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation and prevention. American Psychologist 1993;48:1035–1045.

12. CDC. Sexually Transmitted Disease Surveillance, 2002. Atlanta: US Department of Health and Human Services, CDC; September 2003. Also available at: http://www.cdc.gov/std/stats02/. Accessed July 26, 2004.

13. 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.

For more information...

CDC National STD & AIDS Hotlines:
1-800-342-AIDS
Spanish: 1-800-344-SIDA
Deaf: 1-800-243-7889

CDC National Prevention Information Network:
P.O. Box 6003
Rockville, Maryland 20849-6003
1-800-458-5231

Internet Resources:
NCHSTP: http://www.cdc.gov/nchstp/od/nchstp.html
DHAP: http://www.cdc.gov/hiv
NPIN: http://www.cdcnpin.org