

African-American Sexuality and HIV/AIDS: Recommendations for Future Research

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HIV/AIDS continues to create a significant health crisis in African-American communities and health disparities within the United States. Understanding African-American sexuality within a culturally congruent and ethnocentric approach is critical to decreasing the HIV infection and transmission rates for African Americans. This brief discusses two major factors: 1) confusion about race-based stereotypes; and 2) historical health disparities and mistrust, which have influenced our understanding of African-American sexuality despite that fact that very little research has been conducted in this area. This paper discusses the limitations of what is known and makes recommendations for research surrounding sexuality and HIV/AIDS. Research trainings for new and established investigators and collaborations among health, community, religious, political organizations, and historically black colleges and universities are needed to disseminate relevant HIV prevention messages. Conducting research to better understand African-American sexuality will facilitate the development of behavioral interventions that address health, HIV and mental health risk reduction within the context of African-American life.

Key words: African Americans ■ sexuality ■ HIV/AIDS

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IMPORTANCE FOR AFRICAN AMERICANS

Among 21st-century healthcare crises in the United States, the HIV/AIDS epidemic will long be remembered as one where appropriate prevention and treatment was mired in the centuries-old politics of race, class, health disparities and medical mistrust of the healthcare system. To some, disproportionately high HIV rates would form the impetus for a national effort to garner resources and expertise to prevent new cases, reduce the likelihood of HIV transmission among those most at risk, and ensure that those living with the virus would receive adequate clinical care. While some progress has been made, HIV/AIDS disparities for African Americans in general and for specific subgroups, such as women and men who have sex with men and women, continue to increase.¹ According to the Office on AIDS at the National Institutes of Mental Health, until a vaccine is found, HIV transmission risks are best reduced by decreasing risky sex and drug-related practices.²

Efforts to understand sexual risk-taking and the most common modes of HIV transmission have been studied within a public health context. There have been several HIV-prevention interventions shown to be effective at increasing HIV knowledge and condom use while also decreasing multiple partners and risky injection drug use, particularly needle-sharing among some populations.³ However, little of what we know explains why African Americans are at such a high risk for HIV/AIDS. For example, research has not yet identified the cumulative effects of historical disparities that increase HIV-related risks, and studies that report racial differences often do not examine their etiology. Further, when African Americans are included in research, their national, ethnic or immigration diversity is rarely assessed. They are often compared with whites or Latinos in studies that fail to control for critical demographic differences.⁴ For example, historical disparities in healthcare access and utilization, as well as generational poverty and minimal-to-no health insurance are rarely examined in ethnic populations at risk for or living with HIV/AIDS. These factors place sexual behaviors within a different con-

text that extends beyond risk and is better understood as a result of no information, few facts and silence about these important issues.

Further, it is difficult to assess which behaviors need to change for individuals, couples, families or communities because HIV research does not provide the specific contexts of risks. For example, beyond recommending HIV and sexually transmitted infection (STI) counseling and testing, what questions should health professionals ask individuals or couples who seek premarital advice? What questions should be asked of couples who are ready to have a family? What are the questions that we should ask men who have sex with men or women who have sex with women to assess possible HIV-related risks? When and how should children and adolescents be asked about their in-depth sexual histories? These questions remain unanswered because studies have commonly overlooked the historical, cultural, developmental, religious, relational and institutional factors. Additionally, within African-American communities it has been difficult to explore sex-related issues in general because of embarrassment, conservative values, and a lack of skills in discussing human sexuality.⁵ Parents are often reluctant to discuss facts about sex with their children due to the fear that knowledge will heighten interest and precipitate early sexual activity. The silence regarding sex may further contribute to assumptions that reinforce race-based stereotypes. Consequently, research including African Americans is limited by two major factors that distinguish these sexual risks and have yet to be adequately addressed in HIV/AIDS research. Descriptions of these factors follow.

Confusion about Race-Based Stereotypes and Research

First, there are many well-entrenched stereotypes about African-American sexuality based on misinformation, poor science or assumptions that stem from myths and slave folklore.⁵ One of the most salient stereotypes is that African-American men and women are hypersexual. Empirical evidence that attempts to explain why African Americans are at heightened risks for HIV/AIDS commonly compares African Americans to whites without considering cultural and economic differences, relationship-status imbalances and fears of genocide.^{6,7} The reasons for differences found between groups are often not addressed, and stereotypes are erroneously perpetuated by federally funded epidemiological data and national surveys that report critical correlates of HIV/AIDS by racial groups alone.⁸ The common assumption from these statistics is that most African Americans engage in risky behaviors, especially if they have economic and health resource limitations. Unfortunately, most African Americans are inconsistent consumers of the healthcare system⁹ and often do not utilize health maintenance and disease-prevention services.¹⁰ Subsequently, they do not

receive information regarding health-related behavioral risks, resulting in the highest rates of morbidity and mortality compared to all other racial/ethnic groups.¹⁰ When these health-related factors are not provided to explain the context of risky behaviors, stereotypes of hypersexuality regain prominence.³

The best strategy for addressing stereotypes is to conduct research that accurately describes African American sexuality across the lifespan and factors that affect it. This research needs to be conducted by investigators who are competent to assess the complex factors that affect sexuality and must be disseminated to health providers, ancillary professionals, and community and religious groups. The focus is to normalize the accurate information and dispel myths and stereotypes.

Historical Health Disparities and Mistrust

Disparities in health insurance exist for African Americans as compared with whites. In 2006, 6 million African-American adults were uninsured.⁹ As a group, African Americans encounter numerous barriers to obtaining health insurance, including rates of healthcare coverage, cost and access barriers even when they have insurance.⁹ These issues all contribute to fragmentation in healthcare for African Americans, resulting in delays in seeking services, establishing regular contact with providers, obtaining and keeping follow-up appointments, and obtaining referrals. These factors result in a basic mistrust of the medical system.¹¹ Medical mistrust is based on a lack of healthcare access and equitable treatment by professionals. The assumption is that an individual and the services that he/she provides will be substandard because of racial or economic discrimination. These attitudes and beliefs about the medical system have historical roots in slavery, where African Americans were used in medical and surgical experiments and drug trials.¹²⁻¹⁴ Medical mistrust and limited healthcare access are joined by historical abuses of African Americans in clinical trials and other research that has focused on controlling sexually transmitted infections and reproduction. Specifically, clinical trials for condom acceptability and contraceptive methods, treatment for STIs and sterilization procedures have significantly increased mistrust of healthcare professionals and fears of genocide.¹⁴⁻¹⁷ Health advocacy can be provided in community-based organizations, churches and schools. These skills are needed because trust and transparency are essential for behavior change.

Most recently, an example of an HIV intervention strategy represents a contemporary potential for medical mistrust. Male circumcision in sub-Saharan Africa has been promoted to reduce HIV risks for partners¹⁸ and is also being considered in the United States for at-risk populations.^{19,20} Circumcision is not currently being discussed within the context of history. Adult male circum-

cision may be offered widely to African-American men as a HIV-prevention strategy. However, fears of circumcision, including castration and sexual dysfunction, can contribute to high drop-out rates in research among African Americans, which investigators may not understand. Reasons for concern about circumcision among African-American men should include an acknowledgment of the wealth of literature that compares genitalia size of African-descended versus white men.⁵ African-American men may view this procedure as an attempt to reduce penis size and to render their genitalia as less attractive. Many African tribes historically included male circumcision as a rite of passage into manhood, but the practice was often banned during colonization.⁵ It is curious that similar practices are now condoned without the cultural context in which they were once practiced. Male circumcision needs to be introduced within a cultural framework. Most critically, it needs to be acknowledged as a practice that had relevance to culture and is analogous to circumcision in other cultures.^{21,22} Additionally, cultural values around the esthetics of the male genitalia must be assessed in order to identify other potential barriers to circumcision adherence before this procedure is recommended by health professionals. It is also not clear what benefit this procedure will have on female partners of circumcised men. Without adequate follow-up with couples-based counseling, even if adapted, the procedure may affect relationships in other ways.

Another related factor in understanding African-American sexuality is that study populations in HIV research are often not representative of the diversity of beliefs and practices held by African Americans regarding health and healing. Additionally, HIV-prevention research does not include an assessment of the medical mistrust that may influence high-risk behaviors and treatment adherence in ways that may mediate HIV transmission rates. For example, medical mistrust within subpopulations of African Americans can vary based on age, gender, sexual orientation, insurance status, and healthcare availability and access. Only through reviewing what has been explored and identifying the gaps in what we know will we be better able to direct future research.

WHAT IS KNOWN

The following provides a nonexhaustive review of findings in HIV/AIDS research:

1. While African Americans comprise 13% of the population, they account for 49% of HIV/AIDS cases.¹ Among African-American men living with HIV/AIDS, major transmission categories included male-to-male sexual contact (48%), injection drug use (23%) and high-risk sexual activity (22%). Among African-American women living with HIV/AIDS, major transmission categories included high-risk sexual contact (74%) and injection drug use (24%).¹
2. Patterns for high-risk sexual and drug-related behaviors among African Americans are associated with poverty, being homeless and unemployed, having a history of sexual abuse or mental illness such as depression, and having a history of substance abuse/dependence and incarceration.^{18,23,24}
3. Many African-American men who have sex with men also have sex with women. Recent reports indicate that 14% of African-American men who have sex with men reported sex with women in the prior 12 months, compared with 8% of Hispanic men who have sex with men and 4.2% of white men who have sex with men.²⁵
4. Among young men who have sex with men ages 15–29, 18% of African-American men who have sex with men were classified as “nondisclosers” regarding their sexual activity with other men, compared with 13% of Hispanic men who have sex with men and 8% of white men who have sex with men.²⁶ While these studies involved recruitment in settings frequented by men who have sex with men, studies involving recruitment from other settings found much higher levels of bisexual behavior and nongay identification (20–60%) among African American men who have sex with men.^{27–30}
5. Partner unavailability is a significant predictor of HIV-risk behavior, especially for African-American women.⁵ Relatively high levels of overlapping sexual partnerships (sexual concurrency) are observed within African-American communities.³¹ They are known to increase the transmission of bacterial STIs¹⁸ and may also increase rates of HIV infection.^{32–34}
6. Among African-American women infected with HIV/AIDS, 24% were infected by injection drug use, and 74% had high-risk sexual partners. These figures included 28% with an HIV-infected partner, 12% with injection drug-using partners and 2% with bisexually active male partners.¹
7. The HIV/AIDS health disparity also exists among African-American teens. In 2003, African-American teens ages 13–19 years represented 66% of the AIDS cases in this age category even though they made up only 15% of the teenage population.³⁵ Importantly, African-American teens comprised the single largest group of young people affected by HIV.³⁵
8. The frequency of self-reported sexual abuse before age 18 for African-American women is one in three for HIV-negative women³⁶ and one in two for HIV-positive women.³⁷ The estimated frequency of sexual abuse before age 18 among men varies between 4–76%.^{38–46}

9. In general, high rates of psychiatric disorders, including depression, posttraumatic stress disorder (PTSD) and acute stress disorders (ASD), exist among HIV-positive individuals.⁴⁷

WHAT IS NOT KNOWN

While researchers have been able to document the above findings, the historical, generational, structural and socioeconomic context of African-American sexuality still needs to be examined. Little information exists from a national, regional, age and relationship-related perspective of what factors influence sexual practices. The following are significant gaps in the literature:

1. While researchers have attempted to identify the behaviors that place African-American men and women at risk for HIV/AIDS (i.e., injection drug use, male-to-male sexual contact, high-risk sexual behaviors, etc.), little information is provided to identify the characteristics that describe this group. (i.e., “Who are” the 49% of HIV cases who are African American?) Important questions to answer include: Are poverty, unemployment, health insurance and homelessness correlates of race? Do these variables contribute more to HIV vulnerability than ethnicity/race alone? It is important to understand when behavior is the most risky and the circumstances that heighten those risks. For example, if a male engages in injection drug use for 10 years, has unprotected sex and does not use sterile needles, is he at greater risk than a homeless person or a person who has no healthcare for the same length of time? These are important questions for which we currently have no answers.
2. Patterns for high-risk sexual and drug-related behaviors among African Americans have been associated with poverty, being homeless, incarcerated and unemployed, having a history of sexual abuse, or mental illness.^{3,18,23} However, we do not know which of these factors contributes most to risks of becoming HIV infected or how the cumulative effects of these experiences affect mental health.
3. Recently, research targeting African-American men who have sex with men and women has been recognized as a gap in the literature. Research tends to focus on race/ethnicity, gender and sexual behavior. However, we know little about African-American male sexuality or sexual identity development. We need to examine how sexual abuse, substance use and incarceration histories influence sexual identity development and activity among African-American adolescents and adults, particularly men, as well as the factors that inhibit sexual identity self-acceptance.
4. Partner unavailability has been examined with

- regard to sexual risk-taking.⁵ However, a more global understanding of how limited partner choice, possibly because of incarceration or early death from multiple health issues, affects the African-American family and the community overall. The specific reasons for partner unavailability need to be identified and examined, as well as the consequences on family formation, sexual decision-making and psychological health (i.e., isolation, depression, etc.). For example, marriage could be a risk factor for African-American women if they incorrectly assume their relationship is monogamous and if they do not negotiate for couples-based HIV testing. They may also not know their own HIV status and how their health is affected.⁴⁷ Most of the early HIV-prevention messages did not target married couples and gave the impression that they were not at risk, while not addressing the actual sexual behaviors that could have occurred before or during marriage. Given that large proportions of African-American women are infected by high-risk sexual partners,^{1,48} more research is needed to understand the sociocultural context in which high-risk sex occurs. Understanding the role of limited-partner status in contributing to why African-American women value relationships over self-protection is necessary.
5. While there are data on child sexual abuse among African-American women,^{36,37} there are few, if any, national or regional community studies to better understand the circumstances that increase risk factors for HIV. Most of these incidents among African-American men and women are not reported.⁴⁹ Importantly, there needs to be consensus on the definition of child sexual abuse. Generally, incidents of child sexual abuse include having unwanted or coerced sexual body contact prior to the age of 18.⁴⁹ The severity of these incidents needs to be incorporated in studies of HIV risks, and the evaluation of the effects of nondisclosure is needed. Assumptions are commonly made that a promiscuous child is “sexualized” rather than abused. Importantly, we need to examine the labels attached to African-American men with multiple sexual partners. While this pattern may reflect compulsive sexual behavior and hypersexuality, it is rare but necessary that community stakeholders consider that this behavior is typical of survivors of early and repeated sexual abuse.
 6. We need to understand developmental vulnerabilities in African-American adolescents, especially at ages 13–15 years. Biological changes in puberty, problems with obesity and media influence can exacerbate experiences of isolation and racism that are commonly experienced by African-American youth.

7. More research assessing child sexual abuse and its association to HIV infection is greatly needed for men overall and especially for African-American men.
8. While acute stress is reportedly higher among African Americans than whites⁴⁷, research has yet to examine it within group differences with regard to psychiatric diagnoses among African-American populations, especially those at risk for or living with HIV/AIDS.

RESEARCH RECOMMENDATIONS

Following are steps to understand and prepare for a more comprehensive approach to studying African-American sexuality.

1. Research that describes African-American sexuality is needed. It is difficult to understand sexual risk-taking without first examining African-American sexuality. In doing so, comparisons within self-identified groups are more critical than across ethnic groups. The pathology-based approach currently being used limits the identification of barriers to disease transmission. Research needs to be prioritized to pursue variables most pertinent to African-American sexual health if behavior-change strategies are to be most effective.
2. Understand the sociocultural context of interpersonal relationships and its impact on sexual health. Sexual-health interventions must be framed within a model where individuals and their complex interpersonal relationships are assessed within African-American communities and the community at large.⁵⁰ These interventions should target social networks, individuals, couples, and families, addressing sociocultural variables most relevant to African Americans. The historical lack of healthcare, limited healthcare access, concerns about social isolation and limited partner availability need to be assessed for their impact on risks for HIV/AIDS. Interventions need to address social networks for hard-to-reach populations, including African-American men who have sex with men and those who have sex with men and women. Multidisciplinary groups of African-American experts need to be at the forefront of developing a research agenda that can help to identify what we do not know about African-American sexuality. The cultural, gender, religious and historical variables that can facilitate self-protection need to be included in federally funded research. Further, while public health messages are conveyed to adolescents regarding disease prevention, the endorsement of sexual activity can be implied when there is no indication of what African-American communities expect of their youth. Collaborations among churches, community-based organizations, historically black colleges and universities, and funding agencies (such as the Centers for Disease Control and Prevention and National Institutes of Health) need to be fostered in order to support research priorities of African-American investigators and policy experts.
3. Understand the impact of diversity within African-American communities. While race/ethnicity may be a common factor in identifying populations at risk, there are many variables that contribute to diversity among African Americans. Understanding how age, gender and other socio-demographic variables, as well as HIV serostatus, influence sexuality and sexual decision-making is important. For example, research on methods to reduce the stigma related to the acceptance of sexual diversity within African-American families and communities should receive funding priority. In an effort to increase HIV prevention, a more in-depth understanding of sexuality is necessary to avoid the exclusion of African-American men who have sex with men, men who have sex with men and women, as well as homosexual and bisexual women. Another example of diversity is normalizing the quality of life for persons living with HIV/AIDS. It is important to avoid stigmatizing them and thereby missing the opportunity to truly achieve integration within African-American communities. As an HIV infected individual, disclosing status to your partners and using condoms are necessary for protecting individuals, partners, families and the African-American community.
4. Address cultural elements for African-American interventions. Incorporating ethnocentric research that uses innovative, culturally congruent methods to increase knowledge about HIV transmission, and HIV counseling and testing is needed. Additionally, HIV interventions need to include other sex-related issues, such as prevention and treatment of STIs and contraceptive use, in a manner that is culturally acceptable to African Americans. Separate messages about each of these issues are less than meaningful for African-American populations, who ultimately need to perceive self-protection as a unifying theme.
5. Educational programs about sexuality within a cultural and religious context should be geared toward different age groups. Also, HIV prevention and interventions should assess a basic core of mental health (such as depression, PTSD and anxiety) that are common among African-American populations.⁴⁶ Above and beyond HIV status, these issues may contribute to sexual risk-

taking and should not be overlooked in funded research. We need to be creative in developing culturally appropriate research and care for psychological distress and their effects on health. There is no better time to advocate for a holistic approach to physical, sexual and mental health.

6. Provide sexual health and HIV training to healthcare providers. Given the diverse barriers that African Americans face in achieving good health, it is incumbent on physicians to develop effective communication and clinical exam skills to discuss, diagnose and treat HIV and other sexually transmitted diseases among African Americans.

CONCLUSION

While African Americans are African descended, there is much diversity within this group. This diversity needs to be identified so that all groups, which vary by immigration status, culture, ethnicity or acculturation to the values and norms in the United States, can be understood in relation to their HIV risks. In order to address the research recommendations made above, training in these areas for new and established investigators is critical. Collaborations with health organizations such as the National Medical Association and historically black colleges and universities will ensure that investigators have the skills to conduct culturally congruent research and develop treatment options that address the risks and resilience of African Americans and other African-descended groups. These efforts will help to reclaim healthier sexuality or discover and endorse it for the first time.

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Moffitt Cancer Center & Research Institute, an NCI-designated Comprehensive Cancer Center, is a rapidly growing Center affiliated with the University of South Florida and is committed to education through a wide range of residency and fellowship programs.

The Cancer Center is comprised of a large ambulatory care facility, a 162-bed hospital, with a 26-bed blood and marrow transplant program, 12 state of the art operating suites, a 22 bed intensive care unit, a high volume screening program, and a basic science research facility. The Moffitt Research Institute is comprised of approximately 140 Principal Investigators, 58 laboratories, and 306,000 square feet of research space.

The Malignant Hematology Division specializes in the evaluation, treatment and comprehensive care of patients with hematologic diseases. The program is recognized as a Center of Excellence by the Myelodysplastic Syndromes (MDS) Foundation. It is one of four founding institutions of the Bone Marrow Failure Disease Consortium (BMFDC) recently funded by the National Institutes of Health. All patients with MDS, large granular lymphocytic leukemia, aplastic anemia or other rare causes of bone marrow failure are registered in the consortium's national database, which was developed and is maintained at Moffitt Cancer Center. The BMFDC Consortium is the first and only cooperative network developed by the National Institutes of Health for the study of the biology and development of novel therapeutics for these disorders.

Moffitt Cancer Center is an equal opportunity, affirmative action employer and a drug free workplace, offering generous compensation and benefits packages.

Application Requirements

Applicants must have a Florida medical license or eligible for one, an M.D. or M.D./Ph.D. and be board certified or eligible in Hematology or Oncology, with an interest in the care of patients with leukemia and leukemia clinical research. Prefer experience in a multidisciplinary academic clinical practice setting.

Please reference position no. MCC0706. Interested candidates should send a cover letter, curriculum vitae, and contact information for three references to Alan List, M.D., Professor and Chief, Malignant Hematology Division, c/o Kathy Jordan, MBA, Supervisor Recruitment and Appointment, 12902 Magnolia Drive, Tampa, FL 33612. Electronic CVs preferred to Kathleen.Jordan@Moffitt.org. Positions are open until filled.

Application review begins December 1, 2007.

We employ all individuals based on their merits and attributes