

Structural and Social Contexts of HIV Risk Among African Americans

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HIV continues to be transmitted at unacceptably high rates among African Americans, and most HIV-prevention interventions have focused on behavioral change.

To theorize additional approaches to HIV prevention among African Americans, we discuss how sexual networks and drug-injection networks are as important as behavior for HIV transmission. We also describe how higher-order social structures and processes, such as residential racial segregation and racialized policing, may help shape risk networks and behaviors. We then discuss 3 themes in African American culture—survival, propriety, and struggle—that also help shape networks and behaviors.

Finally, we conclude with a discussion of how these perspectives might help reduce HIV transmission among African Americans. (*Am J Public Health*. 2009; 99:1002–1008. doi:10.2105/AJPH.2008.140327)

HIV IS SPREADING FASTER

among African Americans than it is among other US populations. Specific understanding of the dynamics of HIV transmission and of social structures and processes within and affecting African American communities may help us develop effective HIV prevention methods. To develop more effective HIV transmission among African Americans, we must develop a specific understanding of the dynamics of HIV transmission. In this essay, we present ideas about causal pathways that have received relatively little attention in the HIV/AIDS literature but that might contribute to African American's elevated HIV risk. These pathways suggest areas for future research and action.

TRANSMISSION AS A CONDITIONAL PROBABILITY

HIV transmission occurs as a conditional probability. It requires, first of all, that an HIV-negative person be exposed to the virus. The vast majority of HIV transmission in the United States today occurs during sex or injection drug use. The probability that sex between serodiscordant individuals will result in HIV transmission may be elevated if either party has a sexually transmitted infection (STI). In observational studies, STIs appear to increase infectiousness in HIV-positive people and susceptibility in HIV-negative people.^{1–5} However, recent studies in which STIs have been treated without a concomitant

reduction in HIV incidence cast some doubt on this hypothesis.⁶ Additionally, the infectiousness of an HIV-positive person depends on the person's viral load, which in turn depends upon the person's adherence level, how long the person has been infected, and whether the person is taking antiretroviral medications. Figure 1 illustrates this logic.

The probability that an uninfected person will have an infected sexual or injection partner is a function of both parties' particular social and behavioral histories, their places in social and risk networks, and the combination of social factors and choices that lead them to have sex or inject with particular partners. Networks are links among people; in "social networks" these links are social ties, and in "risk networks" they are ties among people that can spread disease. HIV-risk networks composed of sexual and drug-injection linkages, together with related social-network links, are illustrated in Figure 2. Each risk-network or social-network member possesses an array of relevant characteristics, such as race/ethnicity, gender, HIV status, STI status, the extent to which they engage in normative communication (intravention), the content of any intravention, the strands of racial/ethnic culture in which they are embedded (a concept that is explained later), factors that limit behavioral choice (such as financial need to engage in survival sex, dependence on a sexual partner, housing constraints due to urban desertification,^{7,8} or drug addiction),

and their attitudes to social, prevention, and medical services, among many others. The immediate network of a partnership also has its own HIV prevalence, which may affect the rate of new infections within the network.

HIV infection often clusters among certain parts of a risk network,⁹ which is hardly surprising given that HIV transmission occurs through the high-risk behavior linkages that connect people in a network. Sexual networks also structure patterns of STIs and the consequent impacts on infectiousness and susceptibility to HIV.^{10–14} Social-influence networks are considerably denser than injecting and sexual networks, because most people interact with more people who influence them, or whom they influence, than with sexual or injecting partners.

The characteristics of personal sexual and injection networks are important for understanding racial/ethnic disparities in infection with HIV and other STIs. African Americans are more likely to have HIV-positive injection and sexual partners than are Whites.^{15–17} These disparities result from a combination of the higher prevalence rates of HIV and other STIs among African Americans and a high degree of assortative mixing, i.e., the tendency of members of racial/ethnic groups to have sex or inject drugs with partners from within their own group. This finding helps explain why infection rates are currently higher among African Americans, but it cannot explain how these disparities

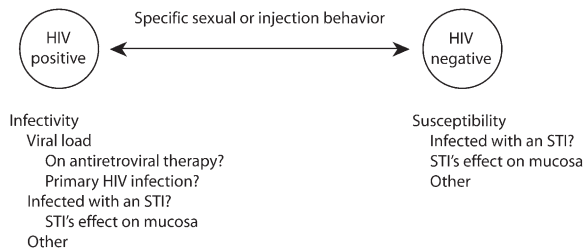


FIGURE 1—Factors in a potential HIV transmission event.

originated.¹⁷ There is no evidence that racial/ethnic disparities in infection rates result from differences in rates of high-risk sexual or injection behaviors per se.

We believe that research on sexual and injection networks in many communities over time is sorely needed to understand why African Americans have higher HIV infection rates. Little of this research has been conducted,¹⁸ but it would help us to learn whether and how networks of African Americans differ from networks of other racial/ethnic groups. This kind of research would also allow us to study how the structures and processes presented in Figures 2 and 3 affect network location and structure, and how these effects operate over time.^{7,8,17} For example, we know

that behavioral subgroups may create subcultural ties that lead to sexual or drug-injection ties. This process is clearest for subcultures that form around attendance at group-sex parties, but sexual networks also seem to occur within drug-using subcultures, which may lead to sexual ties being formed between injecting and noninjecting drug users.¹⁹

Understanding the behaviors that people engage in with each other is also important because behavior change can reduce HIV transmission. Factors that affect a person's behavior include personal characteristics such as knowledge and attitudes, social norms through which social network members exert influence on the person's behaviors, the

personal characteristics of the person's partner, the social normative pressures to which the person is subjected, and the partners' discussions and negotiations concerning the specific behaviors in which they will engage. Like all negotiations, these behavioral negotiations are shaped in part by the resources and social relationships of the people who engage in them. Risk and protective behaviors are also shaped by broader cultural contexts, the actions of social-control agencies such as police (whose tactics may be particularly likely to affect drug-using behaviors, commercial sex activities, and highly stigmatized behaviors such as male-male partner seeking in public environments), and the nature and availability of social and medical services relevant to these behaviors.²⁰

SELECTED DYNAMICS OF HIV/AIDS AMONG AFRICAN AMERICANS

Given this model of HIV transmission through communities, it is clear that HIV transmission and prevention within African American communities should be influenced both by outside forces and structures that shape the economics, culture, social networks, sexual and drug-using networks, and social and medical care of African Americans, and by cultural, social, and political actions, forces, and structures within the African American community. Many of these influencing factors are racialized—that is, structured in accordance with racial categories—in ways that are almost always to the disadvantage of African Americans and other subordinated racial/ethnic groupings. Figure 3 presents some of these interacting forces and processes diagrammatically. It

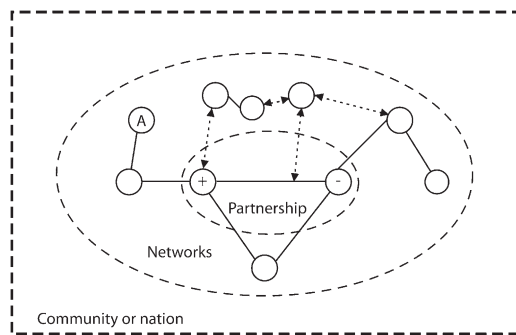
differs from the model presented by Farley¹⁷ in giving greater attention to the specificities of racism, the cultural themes among African Americans, and how these relate to sexual and injection behaviors and their associated risk networks.

It would take many volumes to discuss what is known about the myriad forces, structures, and histories of action that have come together to produce the current high rates of HIV infection and mortality among African Americans. We obviously cannot present this mass of material here. Instead, we emphasize materials that we think have been understudied or underutilized, and we do so within an overall framework that may help us understand how to synthesize existing research and identify issues on which too little research has been conducted. We focus the remainder of this review on some understudied aspects of the relationships of different cultural themes to risk behaviors and of the relationships of social control interventions to HIV-risk and protective behaviors and networks.

This restriction is very selective. For example, we do not discuss the inadequate social and medical resources available to African Americans²¹ and the role that this inadequacy plays in creating the long delays between STI or HIV infection and treatment among African Americans.

CULTURE, RISK BEHAVIORS, AND PROTECTIVE BEHAVIORS

As we consider how behaviors among African Americans are shaped, it is important to remember that infections are not a simple product of behavior alone. This is demonstrated by studies



Note. Circles represent people, solid lines represent shared sexual or injection behaviors, dotted lines represent social influence and normative communication, and dashed lines represent levels of analysis.

FIGURE 2—The contexts of sexual and drug-injecting partnerships.

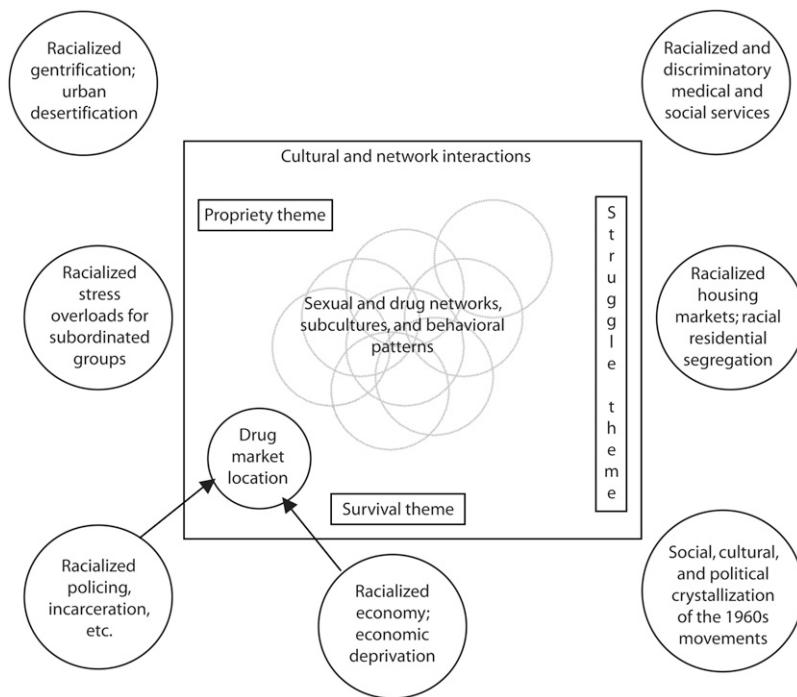


FIGURE 3—Racialized social structures and processes as a context for HIV-relevant cultural themes, subcultures, networks, and behaviors among African Americans.

increase or decrease risk, or to support or oppose public policies or programs to prevent HIV infection. However, to the best of our knowledge, there has been very little discussion of what these themes are within African American culture, how they interact within individuals, families, or larger groups, and how they can best be understood.

RELEVANT THEMES IN AFRICAN AMERICAN CULTURE

We propose that several discrete and interacting cultural themes can be observed in the African American response to the HIV/AIDS epidemic. Research that studies these interacting—and somewhat conflicting—themes in some depth may be very valuable in helping to shape future efforts to prevent HIV transmission among African Americans. (These themes appear inside the box in Figure 3.)

Survival

A “survival” theme is consistently present in African American culture. A subset of the survival theme is the “code of the streets” that Elijah Anderson³² discusses, which centers around a need in some neighborhoods for men to preserve a reputation as being willing to respond to provocation with violence. This code also emphasizes manhood as physicality and as men “scoring” with women sexually. The code of the streets creates cultural environments conducive to high-risk sex, drug dealing, and drug use.

A more positive element of the survival theme is the rapid spread of messages of danger and of ways to avoid it through community grapevines. We noted this as a possible reason why African

showing that although African Americans have higher rates of HIV than do other US populations, they do not have higher rates of sexual risk behaviors.^{16,22} Nor are African Americans more likely to use drugs than other racial/ethnic groups, although they may have higher (but still low) rates of drug injection than do other US populations.²³ Rather, explanations for African Americans’ higher HIV rates probably lie in racial/ethnic oppression, such as discriminatory rates of arrest and incarceration,²⁴ economic deprivation, inadequate access to medical and social care, and differences in the density, turnover, or concurrency of risk networks. Still, risk behavior is important, and interventions to reduce behavioral risk can reduce rates of HIV transmission.^{25–27}

As discussed earlier, culture—particularly social norms and values—helps shape behavior. There is a widespread consensus in the HIV-prevention field that those conducting behavioral interventions must be “culturally competent” in the culture of the population in which they work. Wyatt et al.²⁸ have recently discussed the need to take account of and conduct research on cultural variation within the African American community regarding sexuality. To better understand such cultural variations, we must examine the constitutive elements of African American culture and how they interact with sexual and drug-use subcultures, networks, and behaviors.

Wyatt et al.,²⁸ Chapman and Berggren,²⁹ and Marshall³⁰ agree with Du Bois³¹ that African

American culture has developed through a dialectical interaction among a history of oppression, struggles to survive within an oppressive social order, struggles against oppression, and the various other developments and struggles occurring within the broader community, national, and global social orders. These interactions and experiences have created a mixture of beliefs, ideals, values, norms, and myths within African American populations, meaning that any given African American group or individual has access to a rich variety of cultural traditions as guides for interpretation and action.

Thus, “culturally competent” public health intervention or intervention must be able to understand how these cultural traditions and themes can operate to

American drug injectors reduced several high-risk behaviors to avoid HIV/AIDS more than did either White or Hispanic injectors in New York City in the 1980s.³³

The reluctance of some African Americans to participate in some forms of medical care or scientifically supported risk reduction may also have its roots in the survival theme, given African Americans' long history of medical apartheid and medical mistreatment in the United States.^{34–37} The same might be true for the belief that the government created HIV/AIDS to kill Africans and African Americans.³⁸ These attitudes might lead some African Americans to avoid HIV testing or treatment. In addition, the belief that HIV/AIDS was created to kill African Americans may interact with beliefs that family planning is an attempt to reduce the number of African Americans, causing reductions in condom use.³⁹

Propriety

The socially conservative and traditionally moralistic “propriety” theme reflects the widespread religious involvement of many African Americans and the tendency of oppressed groups to conform to the “official” norms of the dominant social order.^{28,40–43} This theme has contributed to the reluctance of many African American parents to discuss sex with their children²⁸ and to the reluctance of many African American politicians, media outlets, churches, and other organizations to address HIV or to support some HIV prevention interventions, such as syringe exchange.^{40,44} Discussing sex or HIV or establishing programs to prevent HIV among drug users tends to involve talking about “improper” subjects. If such activities are conducted in public, there is a further concern about accepting the racist

stigmatization of African Americans as centers of sexual impropriety and drug use.

The propriety theme may also delay or prevent risky sex or drug behavior in some youth, although we are unaware of any research on this topic. In our experience training frontline HIV public health workers and staff of drug abuse treatment centers, we found that some African American service providers exhibited adherence to the propriety theme during their training. They tended to stigmatize drug use and nontraditional sex. Although many of the drug treatment workers have accepted risk-reduction approaches to drug use, they continue to view sexual risk through perspectives that emphasize abstinence and morality rather than risk reduction. Because a large amount of HIV transmission among both injecting and noninjecting drug users occurs sexually,^{45–48} the strength of the propriety theme among some African American drug service providers may contribute to high rates of HIV transmission.

Struggle

The “struggle” theme in African American culture has grown out of long traditions of both micropolitical struggle⁴⁹ and more overtly political movements against oppression, both within institutions and in the nation as a whole. (“Micropolitical struggle” refers to the numerous but often-overlooked small-scale contestations between local groups of oppressed people and those who dominate them.)

One form taken by this struggle theme is that many African Americans who are responding to the HIV epidemic as outreach workers, researchers, or policy-makers have pasts in the freedom

and Black Power movements of the 1960s and 1970s. These pasts often lead these African Americans to see HIV policies and programs as continuations of past struggles. Their valuable experiences have also given them skills in working with people both collectively and through individual “counseling” interactions.

Both Cohen⁴⁰ and Quimby and Friedman⁴⁴ discuss other aspects of the struggle theme. They present data showing that many African American organizations and officials in New York City and elsewhere responded slowly and unsympathetically to HIV among injection drug users, sex workers, and men who have sex with men. In these authors' analyses, after the uprisings (sometimes called “riots”) of the 1960s and early 1970s, many community organizations, including some drug treatment programs, churches, and community groups, received money and other support from governments and philanthropic bodies in exchange for these organizations functioning as agencies to help control discontent. Over time, this role melded with the status-based propriety-theme moralism that historically has pervaded “respectable” middle-class Black organizations, with the result that these agencies have sometimes responded slowly to the HIV/AIDS epidemic or have opposed certain initiatives, such as syringe exchange.

A better understanding of the dynamics of the struggle theme can inform responses to conflicting interpretations of how HIV/AIDS policy, prevention, and treatment initiatives fit into African American struggles, thus perhaps helping these initiatives win community acceptance.

We know little about how these cultural themes interact with the

norms and values of sexual and drug-using subcultures to affect risk and protective behaviors; likewise, we know little about how these themes shape local HIV prevention and care programs. Research on these issues could be highly valuable to public health efforts.

SOCIAL-CONTROL INTERVENTIONS, RISK BEHAVIORS, AND RISK NETWORKS

The United States is the most repressive country in the world in terms of the proportion and number of residents incarcerated.⁵⁰ Incarceration in the United States is highly racialized. At the beginning of 2008, more than 1 in every 100 US adults was incarcerated in a US prison or jail. The proportion of African American men who were incarcerated dwarfs this national figure, however: 1 in every 15 African American men is behind bars.

Police are less likely to prevent open drug markets or commercial sex markets in poor African American and other “oppressed minority” sections of cities than in White areas.^{9,51,52} This means that outsiders with money—whether African American, White, or otherwise—come to these areas to buy drugs or sexual services, which can be a significant portion of the income coming into some very poor neighborhoods. This money may lure some local youth into the drug trade or the sex trade and thence into unsafe sexual or injecting behaviors.

Racialized processes of police patrol, arrests, and incarceration may also affect the structures of sexual and injection networks in these localities. Because men are more likely to be incarcerated than women, the resulting low male-to-female ratios may reduce

women's ability to negotiate condom use, may lead men to have more sexual partners, and may create higher concurrency in community sexual networks. Furthermore, arrests increase network turnover by removing people from existing sexual and injection relationships. When arrested people return to the community, they may reestablish their previous relationships without disrupting ties formed in their absence. This would create larger networks with more members who engage in risk behaviors with larger numbers of other persons, resulting in a community network with higher levels of concurrency, turnover, and centrality, which can increase the spread of HIV through a community.^{11–14,53}

Policing also directly affects high-risk drug-use behaviors, networks, and interventions. Drug injectors who reside in areas where policing leads them to fear arrest and punishment may avoid syringe exchanges,^{54–56} may inject more rapidly and thus with less effort to avoid infection,^{57–59} or may inject in multiperson injection spots (e.g., shooting galleries)⁶⁰ to escape detection. All of these behaviors are associated with riskier injection practices.^{56,60–62} Arrests may likewise increase risk among commercial sex workers and men who seek male sex partners in street venues.

WHAT INTERVENTIONS MIGHT BE FEASIBLE FOR WHOM?

A wide variety of HIV interventions exist. One critical question to ask of any intervention is: Who is the intervention agent? Given the array of causal structures and relationships we have discussed, it is clear that changing some of these structures or relationships

may require large-scale sociopolitical movements; other structures or relationships may be changed by public health agencies working in conjunction with health service providers and community-based organizations; and changing other relationships or structures may require collective activity—whether organized as intravenation processes or as collective self-organization—from the populations at risk.^{63–66}

In light of these facts, we suggest that the following areas require research or action from public health professionals and agencies to reduce HIV among African Americans. (These suggestions are not meant to deny the importance of traditional behavioral interventions, syringe exchange, condom distribution in prisons, or other efforts; we simply seek to highlight areas that may be less salient in other contexts.)

First, given the ways that social networks and subcultures shape behaviors and structure the flow of STIs through communities, much could be learned if the Centers for Disease Control and Prevention and other health agencies were to alter their HIV surveillance methodologies to obtain drug use and STI data as well as the traditional “risk group” data. Studies have shown that HIV, genital herpes, syphilis, and perhaps other STIs may be particularly prevalent among both noninjecting and injecting users of heroin, methamphetamines, cocaine, and crack.^{67–69} To the (currently debated) extent that STIs facilitate HIV transmission,⁶ and given the elevated rate of STIs among African Americans,^{70–72} we suggest that HIV and STI prevention and care among African American drug users (both injection and noninjection) might help reduce HIV transmission. Such efforts should

be mounted immediately in jails, prisons, drug treatment programs, harm reduction agencies, and STI treatment centers. In addition, harm reduction and drug treatment efforts should be located where people go for STI treatment.

Another major implication of this paper is that social-justice struggles that counteract the racialized economic, social control, and other macro-level social processes that form the outer set of circles in Figure 3 are an important part of HIV prevention in African American populations. One pathway through which this activity can and should occur is large-scale social movements that build upon, deepen, and transform the struggle cultures of African Americans and others. Most governmental health agencies will have at best a limited role to play in such social movements and indeed may intervene to restrain them. Employees of these agencies may be able to be more active than the agencies themselves.

In some instances, health departments, the Centers for Disease Control and Prevention, and other agencies already are addressing HIV-related aspects of policing, social control, and incarceration. For example, in some jurisdictions, agencies within or funded by local governments provide harm reduction training to police so that police officers do not harass syringe exchange clients or sex traders, which greatly facilitates HIV-related risk reduction. These efforts can be extended to incorporate joint health department and police development of police strategies that do not encourage HIV transmission or that reduce incarceration rates, thus reducing the network turnover and concurrency that incarceration produces.

Finally, community groups and health agencies might consider

efforts to establish HIV/AIDS impact assessments (including attention to their possible impacts on racial/ethnic disparities) as review criteria for community redevelopment proposals, police activities, and other community activities. ■

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Contributors

S.R. Friedman conceptualized the article and took major authorship responsibility. H.L.F. Cooper and A.H. Osborne contributed to the thinking behind the article and to its writing.

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Learning From Successful Interventions: A Culturally Congruent HIV Risk–Reduction Intervention for African American Men Who Have Sex With Men and Women

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Few HIV prevention interventions have been developed for African American men who have sex with men or who have sex with both men and women. Many interventions neglect the historical, structural or institutional, and sociocultural factors that hinder or support risk reduction in this high-risk group.

We examined ways to incorporate these factors into Men of African American Legacy Empowering Self, a culturally congruent HIV intervention targeting African American men who have sex with men and women.

We also studied how to apply key elements from successful interventions to future efforts. These elements include having gender specificity, a target population, a theoretical foundation, cultural and historical congruence, skill-building components, and well-defined goals. (*Am J Public Health*. 2009;99:1008–1012. doi:10.2105/AJPH.2008.140558)

AFRICAN AMERICAN MEN WHO have sex with men (MSM) or who have sex with both men and women (MSMW) have the highest HIV prevalence among African Americans and among other racial/ethnic groups of MSM.^{1–3} However, HIV risk behaviors alone do not explain the disproportionate HIV rates among African American MSM.^{4,5} Attention to the sociocultural challenges facing African American MSM is needed.

Only 1 published HIV behavioral intervention targets African American MSM⁶; none specifically target African American MSMW. Inclusion of culture is believed to improve the ability of public health programs to meet members' needs.^{7–9} However, inherent abstractness and a lack of operationalized definitions and cultural competency pose challenges for those designing and implementing interventions.^{10–14} Understanding the experiences of

African American MSM requires attention to definitions of what it means to be African American and of male sexuality that are rooted in African American history and culture. Choices regarding identification with gay or bisexual labels and disclosure of Black same-gender sexual activities must be contextualized within African American communities.^{15–17}

Health improvement among African American MSM requires attention to racism; gender role expectations; connection to partners, families, and communities; and HIV-related stigma.^{18–22} Double minority status is made worse by high HIV rates and perceived responsibility for spreading HIV.^{23–25} Even if family and community provide social support, homophobia and racism can deter African American MSM from disclosing their sexuality and seeking HIV prevention and care.²⁶ Interventions

must engage protective factors and address structural or institutional and sociocultural barriers to prevention.

DEVELOPING A SUCCESSFUL INTERVENTION

We reviewed the Centers for Disease Control and Prevention's *Compendium of HIV Prevention Interventions With Evidence of Effectiveness*²⁷ and identified 6 key elements of successful interventions. These elements were incorporated into a culturally congruent intervention, Men of African American Legacy Empowering Self (MAALES), a community-based HIV risk-reduction intervention targeting African American MSMW.

Components of the Intervention

MAALES involves 6 group sessions lasting 2 hours each and