HIV among African American Men Who Have Sex with Men
Larry D. Icard, DSW and Leonard Goodwin, PhD

The composition of the groups at high risk for HIV has changed drastically since the beginning of the epidemic in 1981. Rates of new infection have declined significantly among White men who have sex with men, while rates of infection continue to rise among African American and Hispanic men who have sex with men. Understanding the dynamics of HIV-related risk among African American men who have sex with men is crucial.

This brief discussion examines the epidemiology of HIV infection among African American men who have sex with men and reviews empirical studies to inform an understanding of the psychosocial, cultural, and economic factors influencing risk behavior. It explores the issues prevention specialists face as they seek to reduce HIV infection rates among African American men who have sex with men.

While African Americans comprise 12 percent of the U.S. population, they account for nearly half (45 percent) of new AIDS cases reported in 1998. In 1989, of all AIDS cases, African American men who have sex with men accounted for 19 percent. By 1998, this figure had increased to 33 percent. Although the mortality rate among all men with AIDS in the men who have sex with men category declined between 1996 and 1997, the decline in mortality rates was lower for African Americans. During this period, among men who have sex with men, there was a 39 percent reduction in the mortality rates among Whites, 26 percent among Hispanics, and 23 percent among African Americans. In addition, current reports reveal that among men who have sex with men ages 13 to 24, the proportion of seropositive African Americans is higher than Whites. Recognizing that HIV disease may be asymptomatic for more than 11 years, it is likely that many African American men who have sex with men became infected at younger ages than their White counterparts.

Over the past two decades, researchers and AIDS prevention specialists have devoted considerable attention to understanding the factors influencing HIV risk behavior among men who have sex with men. Still, the amount of attention directed to African American men who have sex with men has been extremely modest, and providers working with African Americans have had to infer relevant insights from studies comprised largely of White men who have sex with men. From this sparse data have emerged several factors related to risk, including cultural attitudes toward health care and homosexuality, the influence of the Black church, sexual identity, and socioeconomic status, in addition to available social support and social networks. The development of effective prevention interventions for African American men who have sex with men requires an understanding of how each of these factors influences HIV transmission.

Cultural and Religious Attitudes and Values

Despite the enormous amount of attention the media, politicians, and health professionals have paid to the AIDS crisis in the African American community, many African Americans continue to view HIV disease as less of a concern than other public health issues such as violence and drug abuse. Consequently, efforts to motivate African Americans, and African American men in particular, to participate in HIV prevention programs are often received unenthusiastically. This apathy
Editorial: Rationing Benevolence
Robert Marks, Editor

When confronted by the burgeoning epidemic among African American and Latino American men who have sex with men, two conclusions seem unavoidable: there is a fundamental inequality that continues to plague our society, and the response to this inequality is a doomed one in which we are all complicit. In the United States, whenever we talk about funding for health services, the discussion seems to degenerate into a conflict between health care and highways or defense or tax rebates, or between research on HIV disease and research on diabetes or cancer, or between services for injection drug users with HIV and services for gay men with HIV. It’s as if we were not one society with common problems, as if we had no choice but to ration our benevolence.

When I advocate for a strong and sustained response to the epidemic among African American and Latino men who have sex with men, I’m careful not to endorse the attitude that responding to the needs of one community justifies diminishing our response in other communities. The United States has the capacity, if not the will, to research and provide care to all those who are dealing with HIV.

In this issue of FOCUS, Larry Icard and Leonard Goodwin’s overview suggests how research might be applied to develop useful interventions to the epidemic among African American men who have sex with men. Christine Rollet and Mark Winiarski offer insights into one obstacle to HIV prevention and care in African American communities: the historical—and justifiable—distrust of health care systems. This distrust can only be heightened by the scarcity mentality that U.S. society forces upon itself—such an irony today as the tragedy it has always been. The economic “boom” continues and neither government nor the fabled private sector has risen to the opportunity to improve conditions for all people in proportion to the overall health of the economy.

True to the mantra of the 1990s, society emphasizes the role of “personal responsibility” in resolving individual challenges. But in a monumental example of hysterical blindness, many see neither the connection between personal responsibility and collective responsibility nor the relationship between individual challenges and societal problems.

AIDS-specific funding in the United States is a success story not just for people with HIV, but also for U.S. society. It is the story of communities ultimately, albeit slowly, making investments in basic research, care for people with HIV disease, and prevention—a process that suggests a template for dealing with disease in general. But instead of learning from this success story, and appropriately funding research into all major life-threatening diseases affecting every group, many see the disparity between spending on HIV and spending on other diseases as an argument against appropriate investments in HIV care and prevention.

If we must choose, then the epidemiological data demand that we focus on funding a response to the disproportionate growth of HIV in communities of color. But, why is a society as rich as ours mired in a mentality which demands that for every gain there must be a comparable loss? Why must we choose?

References

also grows from the memory of the infamous Tuskegee Syphilis Study, the 1940s investigation that exposed close to 400 African Americans to syphilis and left them untreated (see “Responding to Distrust of the Medical System” on page 5 of this issue of FOCUS). The legacy of Tuskegee is that many African Americans mistrust government-sponsored health programs and view AIDS as a form of racial genocide.

A second cultural attitude that hinders HIV prevention relates to the negative conception that many African Americans hold toward homosexuality. During the early years of the epidemic, June Butts found that some African Americans perceive homosexuality as a White phenomenon that has been inflicted upon African American men. Mindy Fullilove also found that African American homosexual behavior was perceived as incongruent with being Black. Several recent studies suggest that these attitudes remain features of African American culture today. Participation in prevention programs that specifically target men who have sex with men may result in ostracization by the larger African American community.

The Black church has a particularly strong influence on values within the African American community, and many studies have found that African American gay and bisexual men see the Black church as a major supporter of anti-gay attitudes. Of specific concern is the extent to which African American men who have sex with men internalize these negative beliefs, which, in turn, affect their sexual behavior.

The perception of sexual identity by African American men who have sex with men is linked to historical and cultural factors. Historically, the survival of African Americans since slavery has been closely tied to the “manhood” of Black men, a con-
African American men cannot be described by the “tri-dimensional model” of sexual orientation comprised of heterosexual, bisexual, and gay.


cept that includes a range of characteristics such as physical vigor, mental determination, and economic viability. Culturally, African American men are expected to comply with normative gender roles to marry and procreate. Among some subgroups of African Americans, masculinity becomes associated with virility and sexual prowess, which may involve having sex with women and with men.

Several descriptive studies reveal African American men who report engaging in same-sex behavior but who do not define their sexual identity as homosexual or gay.5,6 For example, Joseph Stokes found that White men who have sex with men expressed less discomfort about their homosexuality and were more likely to have disclosed their same-sex behavior to other friends and peers than African American men who have sex with men.6

Taken together, these studies suggest that African American men cannot be described by the “tri-dimensional model” of sexual orientation comprised of heterosexual, bisexual, and gay. The resulting ambiguity of sexual identity may increase the likelihood of sexual risk behavior among African American men who have sex with men. For instance, Timothy Heckman and his colleagues found that African American men who have sex with men were more likely to be seropositive than their White counterparts and less open about their sexual orientation.8 John Peterson and colleagues found similar results, including that men who were uncomfortable about disclosing their same-sex behavior were more likely to practice unprotected anal intercourse.5

Social Support and Social Networks

In recent years, researchers have paid more attention to the normative influences that families, peers, and communities have on an individual’s risk behavior. Several descriptive studies reveal strong associations between an individual’s sexual risk behavior and his or her perception of the support and norms within social networks. For example, Stokes and Peterson found that the extreme isolation many African American gay and bisexual men experience can result in the internalized repression of their gay sexual identity.9 Chief among the responses made by African American men in this study was the perception that homophobia was prevalent in African American communities. One of the unique features of this study is that it includes observations about the southern United States, a geographic region that until recently has been invisible in the HIV research on African American men who have sex with men.

African American men who have sex with men are less likely than White men to be involved in mainstream gay culture (and this is especially true in the South).9 Consequently, these men frequently lack access to institutions and social resources—such as newspapers, bars, and social organizations—that are commonly avail-
able to White gay men. This diminishes the opportunity for HIV providers to reach these men and magnifies the importance of informal social networks—that is, friendships, social cliques, anonymous sexual encounters—as outreach mechanisms.5,7

More than a decade ago Julius Johnson identified two community resources available to African American gay men for their psychosocial support: the African American community and the White gay community.10 Today, however, there is a third choice—the African American gay community—which is evolving its own distinct language, sentiments, and institutions. A number of African American, gay-oriented, self-help organizations have recently emerged, many in response to AIDS. Among these are: Gay Men of African Descent in New York City, the Washington, D.C.-based National Coalition of Black Lesbians and Gays, The National Black Lesbian and Gay Leadership Forum in Los Angeles, and chapters of Brotherhood of Brother, a social organization coalescing throughout the country. In addition, Black gay churches are emerging nationwide. Kraft and colleagues found that it has been these Black gay organizations that have enabled some African American men who have sex with men to feel supported for the first time, both in terms of their racial identity and their sexual orientation.7

**Implications and Future Directions**

Effective HIV interventions for African American men who have sex with men must include strategies to counter the homophobia that exists in the African American community. It is particularly important to develop strategies that counter the negative influences of the Black church on the behavior of African American men who have sex with men. Such strategies might focus on family-centered or community empowerment initiatives.

Of additional concern is the issue of the same-sex behavior that occurs among African American men who do not identify as “gay.” HIV among African Americans appears to occur largely through heterosexual transmission, but as the studies reviewed here indicate, for some African American men, sexual behavior includes relationships with both women and men. HIV prevention must go beyond conventional approaches that selectively target African American men who have sex with men, and move further toward applying systemic approaches that focus on social networks and neighborhoods.

Future research on African American men who have sex with men must move beyond the currently explored geographic areas including New York, Chicago, San Francisco, and more recently Atlanta. Further, researchers and planners must keep in mind that African American men who have sex with men are not a monolithic community in terms of cultural values, religious beliefs, social economic status, political attitudes, or sexual orientation. Finally, African American men who have sex with men meet other men for sex in a variety of venues ranging from bars, bathhouses, and parks to places that offer greater opportunities to form relationships, for example, house parties, social groups, and organizations. Research and prevention must reflect this diversity.

We are only beginning to identify and interpret the various factors that influence HIV risk among African American men who have sex with men. Further attention is needed to identify the most significant variables, define how these variables operate, and develop prevention interventions that target the full range of African American men who have sex with men.

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**Clearinghouse: African American Gay Men**

**References**


Responding to Distrust of the Medical System
Christine Rollet, CSW and Mark G. Winiarski, PhD

Providers who encounter African American clients who are reluctant about HIV-related care should consider whether this response relates to the historical misuse of medical experimentation and treatments in the African American community. For providers of any cultural background, to dismiss such distrust as insignificant, irrational, or “paranoid” would not only be poor practice, but would also repeat the historical dynamic that the “majority culture knows best.” On the other hand, to openly raise this issue and to discuss it in a spirit of partnership could open new avenues of communication in the therapeutic relationship.

Widespread Beliefs
Surveys have found that distrust of majority-culture medical care is a significant part of the African American culture, and these concerns are not isolated to a small number of persons with outlying views. A 1999 survey found that 27 percent of 525 randomly selected African American adults endorsed the statement that “HIV/AIDS is a man-made virus that the federal government made to kill and wipe out Black people.” An additional 23 percent of respondents were undecided. Those who agreed with the “man-made virus” claim tended to be “culturally traditional, male, college graduates who have experienced frequent racial discrimination throughout their lives.” A 1996 telephone survey of 763 low income African Americans and Hispanics living in the Watts section of Los Angeles found that more than half the sample—Blacks more than Hispanics—endorsed statements suggesting AIDS is a conspiracy. In a sample of 25 case studies of poor people, 30 percent of participants believed the government created the virus specifically to kill poor people, with Blacks and Whites equally likely to endorse that sentiment.

John Budin, a New York psychiatrist who talks with clients about antiviral therapies as well as psychiatric medicines, has found that it is not uncommon for African American clients to voice concerns about medications. He says that while Latinos generally accept recommendations to take medications, many African Americans do not, feeling that they are being used as guinea pigs. At the 1999 World AIDS Day commemoration at a South Bronx primary care clinic, several patients raised questions concerning stories that the virus was man-made to infect minorities.

Tuskegee Supports Beliefs
The most-often cited historical basis for these beliefs is the Tuskegee Syphilis Study of the U.S. Public Health Service. From 1932 through 1972, researchers monitored the progress of syphilis among African-American men impacted by HIV/AIDS. The most recent articles on the legacy of Tuskegee describe the current controversial aspects of the study. providers need to address potential condescending or defensive attitudes towards African American clients who distrust the health care system.

References


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399 study participants. But when treatment became available, the researchers deliberately withheld it from this sample of syphilis-infected Black men and their partners. The study procedure has been appropriately condemned since it was revealed in July 1972, but this revelation has also led to rumors that go beyond the ethically bankrupt reality of the study, for example, that participants were deliberately infected. The study remains burned in the memory of African Americans as a prime example of government-sponsored racism, and its effect on African American perceptions of the medical system—particularly evident in attitudes toward HIV—cannot be underestimated.

The HIV-related theories that have arisen in the wake of Tuskegee fall broadly into four categories. First, HIV is a man-made virus that was tested on “undesirables”—gay men and Blacks—with the experiment going out of control. Second, HIV represents a deliberate effort to infect these groups.

Third, the United States and the World Health Organization experimented with new vaccines without adequate purity controls, thereby possibly infecting participants with HIV. A recent example is the claim that a polio vaccine, prepared using the kidneys of primates, was contaminated with simian immunodeficiency virus, which subsequently infected millions of people in Africa.

Fourth, the White establishment is testing new HIV medications on people of color, particularly Black people, and using them as guinea pigs without regard for their safety. This fourth view may be bolstered by recent events in South Africa, where several participants in a nevirapine study died and health authorities have publicly refused to provide zidovudine (ZDV; AZT) to seropositive pregnant women for fear of their safety. This last theory is also encouraged by Peter Duesberg’s assertions that AIDS is not caused by HIV but by recreational drugs and HIV antiviral medications themselves.

In response, the U.S. National Institute of Allergies and Infectious Diseases and the United Nations Programme on AIDS have each posted fact sheets on their web sites that address and dispel Duesberg’s view.

Conclusion

Providers of mental health services who ignore these issues will fail their clients by neglecting their fears. In response, providers need first to be aware of the experiences and resulting concerns of African Americans and to acquaint themselves with the various theories that are considered within the community. Second, providers need to address their own attitudes regarding African Americans and the concerns of African Americans, and determine to what extent they harbor and communicate descending or defensive attitudes about these concerns. Third, providers and administrators should acknowledge that debates about the origin of HIV and the cause of AIDS, the testing of vaccines, and the use of HIV antiviral treatments are already occurring in the African American community. Providers should consider participating in community discussions at their clinics or in community forums. Fourth, when working with African American clients, mental health providers should raise the issue of mistrust in health care systems. It is unlikely that clients themselves will raise this issue to providers of other cultures, for fear of appearing suspicious or paranoid.

The historical relationship between African Americans and medical care systems is particularly relevant to African American clients making HIV treatment and care decisions. Being sensitive to this history and helping clients reveal their fears about treatment is crucial to sustain the therapist-client relationship and to ensure that clients make informed decisions. As a result of these discussions, however, clients may refuse recommended care. The challenge for providers is to respect their clients’ wishes after offering all the options.

New Book on HIV Treatment

The AIDS Health Project announces the fourth volume in its monograph series: HIV Treatment: Mental Health Aspects of Antiviral Therapy: People with HIV—both those for whom treatment has succeeded and for whom it has failed—face a new range of psychosocial challenges. This book covers the new treatment paradigm, the issues it raises, and how to help clients respond.

The book costs $10.95 plus $2.00 shipping and handling, and 8.5% sales tax for California purchasers. Send payment and address to UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884. For multiple, rush, or international orders, call 415-502-4930.
Black and White Differences

In a study of 253 men who have sex with men, African American participants were more likely than White participants to be HIV seropositive, to report past treatment for gonorrhea and syphilis, and to have had recent unprotected sex with a partner known or believed to be HIV-positive.

Researchers surveyed 174 White men and 79 African American men participating in an HIV prevention program in Milwaukee. Study participants answered questionnaires assessing sociodemographic characteristics, HIV and other sexually transmitted disease (STD) history, degree of “openness” regarding sexual orientation, and various HIV risk behaviors.

African American participants were less open about their sexual orientation, scored lower in HIV risk behavior knowledge, had more female sex partners, and used cocaine in association with sex more frequently than did White participants. There was no difference, however, in HIV risk reduction intentions or in attitudes toward condoms. Ninety-one percent of African American participants and 87 percent of White study participants had been tested for HIV, and 51 percent of African American men reported being HIV infected compared to 23 percent of White men. Since the study involved men enrolled in an HIV prevention program, its conclusions may not be generalizable to other populations of African American and White men who have sex with men.

High-Risk Behaviors and Psychiatric Disorders

Gay and bisexual African American men, especially those infected with HIV, may be at increased risk of developing psychiatric disorders, according to a study investigating the psychological effects of HIV infection and substance abuse on 502 urban African American men.

Researchers recruited African American men through HIV test sites, drug treatment facilities, churches, gay-oriented organizations, and media outlets, and by word of mouth. Participants were stratified and compared based on HIV serostatus, drug use, and sexual orientation. All participants underwent tests measuring health status, lifestyle, and psychosocial characteristics. A subsample of 120 participants also underwent brain imaging tests to determine differences in the functional and physiologic effects of HIV infection and substance use.

Sixty-three percent of the sample was HIV-negative, 49 percent identified as gay or bisexual, 56 percent used illicit drugs, and 30 percent considered themselves to be moderate to heavy drinkers. High-risk sexual practices were relatively prevalent—64 percent reported sex with multiple partners within the previous year and 67 percent reported engaging in unprotected sex—and 56 percent had a history of sexually transmitted diseases (STDs).

Twenty-five percent of participants had a current psychiatric disorder, and 45 percent had a prior history of at least one major psychiatric disorder; gay and bisexual men and HIV seropositive men showed greater psychiatric vulnerability. Anxiety disorders were the most common: 21 percent had current anxiety disorders and 37 percent reported past illness. Mood disorders were the second most common: 9 percent currently met diagnostic criteria, and 24 percent reported a history of such disorders.

Culture-Specific Communication
Myrick R. In the life: Culture-specific HIV communication programs designed for African-American men who have sex with men. *Journal of Sex Research*. 1999; 36(2): 159-170. (Auburn University, Alabama.)

A review of the HIV communication programs used to reach African American men who have sex with men identifies innovative and culture-specific programs, but issues of identity and discrimination continue to hinder the ability of these efforts to reach their target audience.

Researchers focused on the four largest and oldest gay and African American AIDS service organizations in the Southeast and Northeast regions of the United States. The organizations were designated A, B, C, and D. Organization A focused its efforts on
outreach in African American gay bars, and organization B used erotic poster campaigns. Both organizations A and B had experienced difficulty reaching men who do not identify as gay but who have sex with men. In a survey of men at African American gay bars, organization A found that only 50 percent of men who engaged in same-sex behavior identified as gay.

Organizations C and D focused on African American communities in general, specifically trying to appeal to men who have sex with men but who do not identify as gay.

Intervention efforts included informational campaigns, prevention through networks, and workshops. Organization A, for example, used gay-focused brochures that explicitly highlighted various sexual behaviors, corrected misconceptions about HIV, and promoted safer sexual behavior with erotic, sex-positive messages. To reach men who do not identify as gay, organizations C and D minimized explicit references to same-sex behavior. Workshops encouraged participants to talk about their lives, including experiences with racial discrimination and various sexual behaviors. In this way, HIV educators connected HIV disease with other health issues and life experiences and then presented HIV prevention as part of an overall strategy for self-empowerment.

Despite accomplishments in understanding and responding to the complex experiences and needs of African American men who have sex with men, every educator interviewed expressed concern about the extent to which culture-specific communication programs were actually resulting in safer sexual behaviors among target populations.

Income and Gender Identity


A presentation of historical, ethnographic, and qualitative research of low-income African American men suggests that historical and political events greatly affect a person’s sense of self, especially as it relates to gender identity, and can undermine the ability of HIV prevention programs to reach African American gay men.

The commentary combines historical reviews of the African American experience in the United States with original research on 350 African American men. The research identified at least three attributes of masculine gender identity that act as barriers to the adoption and utilization of condoms by African American men: biological parent-
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