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**Working Title: STI Disparities and Social Work: A scoping review of historic disease
prevention models within African American Communities**

Kaylisa Estes
Graduate Student

School of Social Work, Clark Atlanta University

Abstract

This research explores the ongoing sexually transmitted infection (STI) epidemic within African American communities. It seeks to trace epidemiological, historical, and sociocultural roots of care delivery. The Social Determinants of Health (SDOH) including poverty, healthcare accessibility, stigma, and systemic forms of discrimination. Parallels between historic contributions within the field of healthcare to the current pandemic rates of infection within the community are presented. The author centers the field of Social Work as a needed sector of engagement. The author desires for the implementation of the Social Work skillsets of resource brokering, harm reduction, and engaging ethical care models. Historical trauma is discussed with emphasis on the reproductive exploitation during slavery and unethical medical experiments. The importance of culturally grounded, and interdisciplinary interventions are presented as models useful to rebuild trust and promote equitable care within the scope of sexually transmitted infections within African American populations.

Keywords: Social Determinants of Health, historical trauma, sexually transmitted infections, culturally responsive interventions

Introduction

In 2024, the Centers for Disease Control and Prevention (CDC) released a report about the sexually transmitted infection (STI) epidemic in the United States. Although the rates of infection are slowly declining, sexually transmitted infections such as gonorrhea and syphilis remain disproportionately high among marginalized populations, especially those who identify as Black or African American (CDC, 2024).

Jenks et al. (2023) found that in North Carolina, STI rates strongly correlated with Social Determinants of Health (SDOH). Social Determinants are social factors that impact an individual's health outcomes. Common factors assessed in the SDOH frameworks include, (1) insurance accessibility; (2) transportation; (3) poverty, and (4) geographic isolation. Earlier research by Noonan et al (2016) found parallels in commonly assessed social determinant factors and the rising STI rates within African American communities. Their research identified poverty, incarceration, discrimination, and limited healthcare accessibility as key drivers of the elevated infection rates, while Lieberman et al. (2021) echoed these findings, confirming that African Americans and Hispanic populations continue to bear the highest burden of STI-related morbidity. The root causes seem to be tied to deeply entrenched social and environmental determinants.

It is imperative for clinicians and social workers to implement prevention strategies that address both clinical and contextual factors. The role of Social Workers can focus on advancing the justice-based models of care. By doing so, the researcher seeks to shift narratives associated with STI stigma, medical mistrust, and encourage integrated cultural models of care delivery in the future.

Historicism of STIs in African American Populations

When addressing modern Sexually Transmitted Infection (STI) health disparities among African Americans, scholars and practitioners should consider the historical context that shaped reproductive and sexual health outcomes. Much of the existing literature focuses on behavioral interventions, and yet fails to account for legacies of racial trauma, exploitation, and mistrust rooted in slavery and even medical abuse. Painter (2005) traced the origins of African Americans in the U.S. to the transatlantic slave trade, where millions of African Americans were subjected to inhumane conditions while aboard ships which continued in the slave markets (Wood & Rawley, 1982). Aboard these vessels, enslaved individuals suffered from disease, inadequate hygiene, and sexual violence, which then spread venereal diseases (Santa Clara University & Rickwa, 2024). Also, unqualified surgeons often performed experimental or unethical procedures to keep enslaved Africans alive long enough to sell them (National Museums Liverpool, 2025).

Each regional port of Transatlantic Enslavement was regulated by varying legislation surrounding reproductive care practices pertaining to the enslaved. To highlight regional

differences in structure, the U.S. chattel slavery system placed greater emphasis on reproduction than that of Caribbean systems. And, “slave breeding” was used to ensure generational free labor supply (Smithers, 2013; Mintz & Gilder Lehrman Institute, 2024). Once in the United States, enslaved people were sorted by gender, fertility, and labor potential, which further institutionalized reproductive control (Baker & College of Charleston, 2013; Kennedy et al., 2023).

Literature Review

It is well documented that plantations used to regulate sexual relationships, enforced reproductive labor, and weaponized sexual assault to dehumanize and control Black people (Berry & Harris, 2018; Berthelet, 2023). Feinstein (2019) noted that sexual violence was often used to assert dominance, maintain social order, and reinforce white masculinity as well. The content of Harriet Jacobs’ (2020) autobiographical explains the pervasiveness of sexual abuse, forced breeding, and fragmented family systems during this era. Mintz’s scholarship supports Smithers’ assessment, emphasizing how the reproductive control of enslaved people in the United States contributed to population growth, economic sustainability in the South, and generational continuity among African Americans (Mintz & Gilder Lehrman Institute of American History, 2024). Within the chattel slavery institution, sexual practices and autonomy were strictly regulated by enslavers. Berry et al. (2018) found that enslavers often enforced sexual violence, restricted intimate relationships, and controlled reproduction through systematic breeding, thus resulting in fragmented family systems. Feinstein (2019) further documented how sexual violence, particularly rape, was used by slave owners as a tool of domination: “to control, humiliate, and degrade enslaved women and men, increase slave labor and property by impregnating the women, and provided an avenue for white male bonding and white masculine performances”.

Though different in construction, both the Caribbean and U.S. slavery systems shared common practices. Both included sexual exploitation, forced concubinage, and denial of reproductive autonomy (Burnard & Follett, 2012). Venereal disease (VD) was prevalent among enslaved populations, and the stigmatization of these diseases by colonists contributed to the mistreatment. Then myths that erroneously medicalized and pathologized sexual behavior among African Americans formed (Burnard & Follett, 2012). This is significant since as western medicine began to evolve in conjunction with localized and global systems of enslavement, similar racialized medical ethics developed. Soon stereotypes of African hypersexuality were used to justify not only slavery but also reproductive control and medical experimentation (Davis & Jordan, 1969). Even in the year of 2025, one has to still consider the unethical experimentation of the 20th century with the Tuskegee Syphilis Study. This infamous test, conducted in Macon County, Alabama, from 1932 to 1972, involved 600 Black men. The results showed that 399 Black men contracted syphilis and 201 did not contract the virus (Tuskegee University, 2025). Testing ethics were violated as these poor sharecroppers were not given informed consent, nor

were they offered treatment (CDC, 2024; Tuskegee University, 2025). Even after penicillin became the standard in 1947 (discovered in 1928 by Alexander Fleming, a Scottish biologist), such practice continued far too long (Tuskegee University, 2025). No doubt, the experiment resulted in multiple deaths, infections of partners and children, and long-lasting medical mistrust among African Americans. Inevitably, a class action lawsuit awarded \$10 million to surviving participants and their families (Tuskegee University, 2025). But this did not rid Blacks of mistrust, and a *vote of no confidence* (Scharff et al, 2010; Shukla et al, 2025). In fact, Freimuth et al. (2001) found that even decades later, African Americans in Los Angeles, Chicago, Washington, D.C., and Atlanta remained skeptical of medical research due to the study's legacy. Such mistrust was noted during the COVID-19 pandemic as well. Hou et al. (2024) found that hesitancy around COVID-19 vaccination among African Americans was rooted in the Tuskegee Study.

These historical injustices underscore the deep-rooted nature of medical mistrust, and the pervasive impact it has as a social determinant of health. As such, any interventions aimed at reducing STIs must not solely be clinically sound but both culturally responsive and ethically centered. Social workers' skillsets play a critical role in marginalized communities by first assisting with rebuilding trust, equitably distributing resources, and the ability to advocate for justice-driven public health frameworks (Hill et al., 2022). This next section will overview the importance of social theory into the formation of medical models of care

Discussion

As social workers engage in the work of Sexual Transmitted Infection prevention and reproductive health, it is imperative to employ frameworks such as the Social Determinants of Health (SDOH), social stratification, resource delivery, and stigma reduction in future interventions. Social workers operate within the social sphere of care delivery, family engagement, and discharge planning within medical settings. However, as seen throughout history and contemporary practice, medical settings are not limited to clinical environments. Medical settings are formed and shaped by the social attitudes and behaviors of both individuals and communities. If practitioners rely solely on diagnostic interventions, they risk overlooking the social, mental, and environmental stimuli that influence patient health outcomes.

One way to address this gap is for both social workers and interdisciplinary healthcare professionals to implement social interventions when working with communities impacted by medical mistrust and abuse. Utilizing frameworks from social theory strengthens how social workers promote effective care delivery strategies within community centered settings. Thimm-Kaiser et al. (2023) emphasize that research focused on social determinants should not only reveal inequities but should also assist with the transition of care delivery interventions into that of heuristic models. Heuristic models generate data that assist with the reduction of negative health outcomes within populations. Implementing history and data into practice allows for

policymakers, practitioners, and researchers to utilize socially determinant based care delivery models for strategic implementation. In order to do so, social workers and interdisciplinary team members should seek to understand how health risks are impacted within social structures.

Burton-Jeangros purports how health risks are exacerbated by systemic social structures. Power relations, resource accessibility, and one’s social status all influence healthcare accessibility and patient outcomes. Sociologists call this social stratification which is defined as “the systemic ranking of people or groups of people that characterizes all known societies” (Budowski & Tillmann, 2023, p. 7). Correlational research surrounding social concepts and public health models agreed that one’s stratification status directly affects their healthcare experience and outcomes (2024).

Thimm-Kaiser (2023), present a conceptual model, the Center for Latino Adolescent and Family Health Framework of SDOH Mechanisms, which helps assess how social processes and capital affect individuals at micro, mezzo, and macro levels. This model also evaluates exposure, susceptibility, and resilience across the life course. Integrating these concepts their research enables a multifaceted understanding of inequities. Applying a model like this, practitioners and policymakers can ethically design interventions that improve well-being across diverse communities, and multiple organizations.

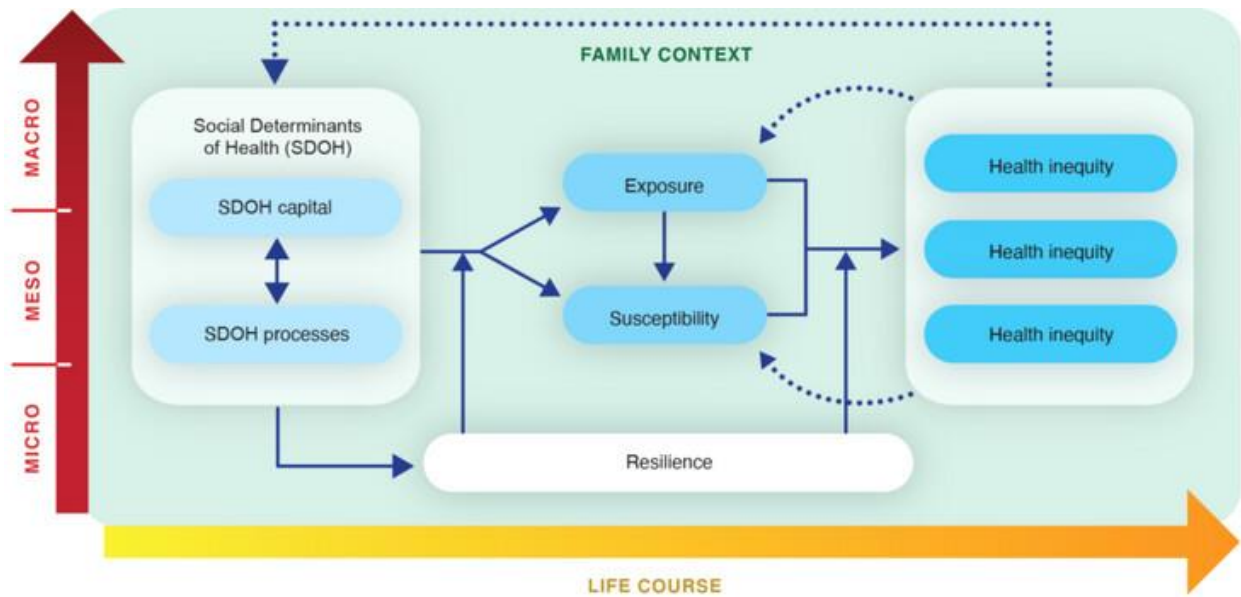


Figure 1. The Center for Latino Adolescent and Family Health Framework of SDOH Mechanisms.

Incorporating this frameworks, shown by Figure1, into the field of Social Work enables integration between healthcare, social theory, and data acquisition. This multidisciplinary approach allows for the development of interventions informed by both social models and

empirical data. Through such integration, the author seeks to reduce stigma, improve resource delivery, and provide comprehensive assessments showcasing how social determinants affect disenfranchised populations.

Conclusion

Culturally Responsive Interventions for African American Communities

As providers and practitioners develop targeted interventions for African American communities, it is critical to move beyond traditional, facility-centered models of care. Historical experiences of medical mistreatment—from slavery-era experimentation to modern-day health inequities—have created deep mistrust toward institutional healthcare among many African Americans. As a result, reintegrating rigid or culturally unresponsive systems may retraumatize rather than assist with disease prevention efforts. Interventions must therefore prioritize flexibility in location, delivery, and engagement. Care models that incorporate home-based services, trusted community buildings (such as churches or cultural centers), and reputable provider networks can foster greater associations with comfort and trust. Geospatial accessibility and cultural safety must guide where and how care is delivered, particularly in regions shaped by medical deserts and the destabilizing effects of gentrification

The accessibility, effectiveness and public health responses must integrate culturally grounded care with innovative biomedical solutions. This includes promoting pharmaceuticals such as Doxy PEP and PrEP, while simultaneously addressing the historical mistrust associated with pharmaceutical interventions. Education and outreach must be rooted in culturally competent messaging that validates lived experience, affirms sexual autonomy, and centers reproductive justice. Mobile health clinics, digital media interventions, and culturally adapted prevention campaigns can serve as effective conduits for change. Interventions should also be designed with community input and implemented by trusted messengers. Programs that reflect and respect African Americans can rethink needed preventions This work can begin with building trust, restoring access, and promoting holistic sexual autonomy for historically marginalized populations (Kennedy et al. (2023).

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