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Feminist Approaches to Epidemiological Research and Interventions: Addressing the HIV/AIDS Epidemic among African American Women

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Abstract

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There is an increasingly urgent need to develop effective and sustainable interventions that can curb the HIV/AIDS epidemic among African American women in the US. In this project I analyze the underlying conceptions of identity and social structure that many public health researchers draw on when theorizing about the causes of and interventions for African American women's high HIV transmission rate. Utilizing Chandra Talpade Mohanty's theory of identity production through local power systems, I suggest that monolithic understandings of African American women's identity limit epidemiological research by obscuring how particular African American women's identities are constructed through social forces and how this identity development contributes to HIV transmission. Furthermore, drawing on Michel Foucault's formulation of power, I argue that thinking about contextual forces (e.g., social structure and culture) as all-powerful arrangements limits public health interventions to two general approaches: 1) abstract social change or 2) limited, individualized behavior modification. I propose that Mohanty and Foucault's theories offer a useful conceptual framework for envisioning how tangible structural interventions can generate lasting health benefits. Moreover, I suggest that Foucault's conception of power offers a model for designing structural interventions based on an understanding of *positive deviance* (PD). This theory states that within any community plagued by a particular disease there is always a subset of at-risk individuals who remain healthy by engaging in particular kinds of behaviors. I conclude by exploring how a systems approach to PD research can unearth effective strategies for reducing the disparate rate of HIV infection among African American women.

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Introduction

From a feminist perspective, theories that analyze human dynamics are most valuable when they offer strategies for change. Since feminism aims to create more equitable social relations, useful feminist theories not only describe social interactions but also offer blueprints for attaining equality. As feminist scholar Charlotte Bunch states, "A solid feminist theory would help us understand present events in a way that would enable us to develop the visions and plans for change" (248). Similarly, explanations of health disparities are most useful for public health practitioners when they provide strategies for effective interventions to reduce such inequalities.[1] Unfortunately, theoretical explanations of health disparities have not offered effective strategies to curb the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic among African American women – a current public health crisis. This project teases out the underlying theories of identity and social structure that inform some epidemiological research and interventions addressing the disparate rate of HIV transmission among African American women. I explore how some public health researchers' ability to understand and intervene into this epidemic is limited by their traditional conceptions of identity and social structure. I suggest alternative formulations of identity and social structure that may guide effective strategies for understanding and reducing the disparate rate of HIV infection among African American women in the US.

Before moving further, it is important to recognize that many public health efforts targeting African Americans, and African American women in particular, have a

[1] Other groups interested in health disparities, such as policy makers, also benefit from theories that offer effective strategies to reduce health inequalities. This project focuses on public health practice and its practitioners.

troublesome history. There are countless examples of public health practitioners inappropriately ascribing disease to African American women in order to justify the control of African American women's behaviors. In *To 'Joy My Freedom*, Tera Hunter documents how early 20th century public health practitioners justified the regulation of female African American domestic workers by claiming that they were responsible for tuberculosis outbreaks among white American southerners (187-218). Public health initiatives have also negatively impacted the very health of African American women. Riding on the wave of the eugenics movement of the 20th century, some programs sponsored by the US government either forcibly or coercively sterilized African American women in the name of public health (Ordover 125-178). Although a comprehensive exploration of the problematic public health history concerning African American women is outside the scope of this project, these few examples serve as reminders that current initiatives to reduce the HIV/AIDS transmission rate among African American women are part of a disturbing historical narrative. It is with this understanding that we can engage current public health research, actively analyzing how our current efforts may be reproducing historical injustice.

The history of the HIV/AIDS epidemic in the US is also fraught with political tension. These political concerns range from the initial unresponsiveness of the US federal government to the stigmatization of gay men and the racial politics played out in rhetorics of the "down low." There is also an extensive literature addressing the problematic media portrayals of African American women with HIV/AIDS. For example, in 1997 Evelynn Hammonds documented how the few existent representations of African American women with HIV/AIDS simultaneously rendered them invisible (excluded

from the "innocent symbols" of AIDS victims) and exposed (relegated to the categories of drug abusers or bad mothers) ("Seeing AIDS"). However, these topics are beyond the focus of this introduction. Instead, I will provide background information on HIV/AIDS, contextualize the HIV epidemic within the US, and document the disproportionate burden of HIV/AIDS suffered by African Americans and African American women in particular.

HIV is a virus that infects humans and damages the human immune system.[2] HIV can be transmitted through blood (e.g., sharing needles with an HIV-positive individual or receiving HIV-positive blood during a blood transfusion), semen and vaginal fluid (e.g., having oral, vaginal, or anal sex with someone infected with HIV) and breast milk (e.g., an HIV-positive mother breast feeding a child). Once someone is infected, HIV then attacks cells that are necessary for the proper functioning of the human immune system, thereby weakening the immune response to other diseases. If HIV damages one's immune system so that it can no longer effectively protect against disease, the person can develop AIDS. An AIDS diagnosis is based on the presence of certain infectious diseases or cancers that are not normally found in the general population. AIDS can also be diagnosed if the concentration of certain immune system cells drops below a set level, indicating that the immune system can no longer function effectively.

Current scientific evidence suggests that HIV was introduced into the human population in the 1940s or 1950s. Researchers believe that humans first acquired HIV-1, the most common strand of HIV in the developed world, from the blood of chimpanzees that were infected with a similar simian HIV strain. It is thought that this transfer

[2] The information in the following six paragraphs was taken from the Centers for Disease Control and Prevention (CDC) websites on HIV/AIDS: "Estimates of New HIV Infections in the United States," "HIV/AIDS among African Americans," "HIV/AIDS and African Americans," "HIV/AIDS Basic Information," "How Does HIV Cause AIDS?," "*MMWR* Analysis Provides New Details on HIV Incidence in U.S. Populations," "What is AIDS?," and "Where did HIV Come from?"

occurred in Africa when humans were exposed to infected blood while hunting and/or eating a specific subspecies of chimpanzees called *Pan troglodytes troglodytes* (Gao et al. 436-40). Once the simian HIV strain transferred to humans, it was then able to pass between humans. According to current scientific understandings, after first infecting humans in Africa, HIV then spread throughout the rest of the world.

HIV had traveled to the United States by at least the mid-1970s. In 1981, medical doctors first recognized clinical manifestations of HIV infection after five men who have sex with men (MSM) were diagnosed with *Pneumocystis carinii* pneumonia (PCP) in Los Angeles, California (CDC, "First Report" 429). After these initial cases of AIDS (although the term "AIDS" was not adopted until 1982), HIV spread exponentially in the US throughout the 1980s and the early 1990s. In the early 1980s, most HIV/AIDS cases in the US occurred among white American MSMs. However, throughout the 1980s the HIV/AIDS epidemic began to significantly impact other populations as well (CDC, "HIV/AIDS – United States, 1981-2000" 430).[3]

During the early 1980s, African Americans increasingly acquired HIV. This gradual increase culminated in 1987 when the number of new HIV cases among African Americans was greater than the number of new cases among white Americans. In fact, from 1987 until 1990 there were at least 20,000 more new cases of HIV infection among African Americans compared to white Americans. Since 1987, African Americans have continued to have the highest rates of HIV transmission compared to all other racial groups in the US. The most recent analysis of HIV incidence rates dates to 2006, when the rate of new infections among African Americans was seven times greater than the rate

[3] This understanding reflects current scientific evidence. It is possible that differential testing has underrepresented the amount of HIV/AIDS among non-white Americans during the early 1980s.

of new infections among white Americans. Although African Americans comprised only 12% of the total US population in 2007, they accounted for 51% of all HIV/AIDS diagnoses.

The disproportionate burden of HIV/AIDS among African Americans is magnified when we compare African American women to white American women. In 2006, the rate of new HIV cases among African American women was nearly *fifteen* times higher than the rate among white American women. Similarly, in 2005, African American women accounted for 64% of all women diagnosed with HIV/AIDS. Clearly, there is a need to identify why African American women disproportionately suffer from HIV/AIDS compared to other women. Chapter 1 explores the common epidemiological understandings of the increased prevalence of HIV/AIDS among African American women.[4]

Recognizing the disparate rate of HIV/AIDS among African American women, many public health practitioners began developing HIV prevention strategies in the 1990s to address the epidemic. In Chapter 2 I review the common types of interventions designed to curb African American women's high HIV transmission rates. It is noteworthy that despite these efforts African American women continue to shoulder a significantly disproportionate burden of HIV/AIDS. Thus, there is still a need to develop

[4] When considering the epidemiology of HIV/AIDS among African American women, I should note that the risk factors and geographic areas associated with women's HIV infection have shifted since the start of the epidemic. In the beginning of the epidemic, most women acquired HIV through injecting drug use. However, by 1995 heterosexual sex became the leading route of HIV transmission for all women, and especially African American women. In 2005, heterosexual sex accounted for 74% of all HIV/AIDS cases among African American women (compared to 65% for white women) (CDC, "HIV/AIDS among Women"). Related to the shift in transmission route, the geographic prevalence of HIV/AIDS among women has changed throughout the epidemic. Although the northeastern US had the highest incidence rates of AIDS at the start of the epidemic, by 1998 the southern US had the highest proportion of new AIDS cases (Hader et al. 1187). Moreover, African Americans comprise the vast majority of reported new AIDS cases in the southern US. Of the 4,944 AIDS cases reported in the southern US in 2007, 3,734 were African American women (CDC, "HIV/AIDS Surveillance in Women").

widespread and sustainable HIV prevention strategies to address the HIV/AIDS epidemic among African American women.

Feminist scholars have been critical of the public health response to African American women's high rates of HIV infection. Perhaps the most influential of these scholars is Evelynn Hammonds. She has documented the medical establishment's failure to prevent sexually transmitted diseases (STDs) among African American women since the 19th century ("Missing Persons"). Hammonds argues that the failure of many STD/HIV prevention efforts targeting African American women results from a lack of historical and contemporary analysis into how race and gender dynamics affect public health initiatives. My project complements this work by offering conceptual tools for thinking about identity and social structure in general, thereby equipping researchers with a new approach to understanding how race, gender, class and other identities affect disease transmission and public health interventions.

Within the public health literature, the most common critiques of existing HIV interventions targeting African American women focus on cultural competence. During the 1990s there was widespread concern that interventions among African American women were not tailored to the cultural norms specific to African American communities. For example, in "HIV/AIDS Case Profile of African Americans: Guidelines for Ethnic-Specific Health Promotion, Education, and Risk Reduction Activities for African Americans," public health practitioner Bassey Williams argues for culturally competent HIV prevention strategies:

> Culturally sensitive and ethnic-specific health education and health promotion programs are advocated for the African American population… The goal of such programs, aimed at modifying behavior, must take into consideration cultural and behavioral patterns, socioeconomic factors, social norms, as well as ethnographic infrastructure of the African American community. (300)

Although the generalization inherent within any reference to "*the* African American community [emphasis mine]" (Williams 300) is cause for concern, the general idea of tailoring interventions to specific communities is an important consideration for successful public health interventions.

However, most of the public health literature on HIV interventions among African American women lacks analysis of the underlying theories of identity and social structure that impact the design and interpretation of epidemiological studies and interventions. In fact, certain notions of identity and social structure are assumed as unquestionable truths throughout most of the literature. For example, in "Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women," Gina Wingood and Ralph DiClemente explore how R. W. Connell's understanding of gender and power provides insight into the gender relations within specific communities. While discussing the difficulty of applying Connell's theory of gender and power to public health practice, Wingood and DiClemente explicitly state their underlying conception of social structure:

> Applying the theory of gender and power to understand the influences of women's health can be challenging. *Social structures are often abstract, difficult to operationalize, and do not take into account variations across different cultures.* Moreover, when applying the theory of gender and power, it can be difficult to isolate and tedious to quantify the effect of a particular social structure on women's health. [Emphasis mine.] ("Application of the Theory of Gender and Power" 556)

Wingood and DiClemente define "social structures" as intangible societal frameworks that encompass various cultures. That is, they tend to think of social structures as broad, monolithic arrangements. It is perhaps no surprise, then, that they feel it is "difficult to isolate and tedious to quantify the effect of a particular social structure on women's health" (Wingood and DiClemente, "Application of the Theory of Gender and Power" 556). Other scholars formulate social structures quite differently from Wingood and DiClemente. They might see social structures more as specific relations between people, organizations and institutions. It is my argument that notions of identity and society impact the way public health practitioners design epidemiological studies and interventions. As Wingood and DiClemente acknowledge, their conception of social structures makes it difficult to apply Connell's theory of gender and power to epidemiological research. A different understanding of social structures may make it easier to comprehend how social structures impact women's health.

This project examines how underlying theories of identity and social structure affect epidemiological research and health promotion strategies addressing the

HIV/AIDS epidemic among African American women. In Chapter 1 I examine the dominant epidemiological understandings of African American women's disproportionate rate of HIV infection. I argue that most epidemiological research and interventions are limited by underlying notions of static identity and omnipotent contextual environments (e.g., social structure and culture). In "Under Western Eyes," the prominent postcolonial feminist theorist Chandra Talpade Mohanty argues that understanding identity as a pre-given fact limits our analysis of how identity is produced within local contexts. I suggest that assuming a static "African American woman" identity also limits epidemiological research by obscuring how particular African American women's identities are constructed through social forces and how this particular identity development contributes to HIV transmission. Mohanty also contends that unitary understandings of oppressive social structures fail to provide strategies for attaining equality. From this perspective, I argue that conceptualizing contextual forces as all-powerful constructs restricts frameworks for intervention to either the abstract transformation of contextual environments or the limited targeting of individual African American women's behaviors.

Chapter 2 explores how these theoretical constraints have limited many of the actual interventions implemented to address the HIV/AIDS epidemic among African American women. It focuses on why public health practitioners have rarely implemented structural interventions to address the larger societal factors that facilitate HIV transmission, especially since most researchers agree that social structures largely shape African American women's disparate HIV infection rate. I propose that Michel Foucault's understanding of power systems as dynamic webs of force relations and

Mohanty's notion of identity production provides a useful framework for imagining sustainable health benefits through structural interventions.

The last chapter builds upon the first two by analyzing how a new articulation of social systems can inspire alternative approaches to researching and intervening into the HIV/AIDS epidemic among African American women. I suggest that Foucault's conception of power offers a model for designing structural interventions based on an understanding of *positive deviance* (PD). This theory states that within any community plagued by a particular disease there is always a subset of at-risk[5] individuals who remain healthy by engaging in particular kinds of behaviors (Marsh et al. 1177). Drawing on Foucault's notion of power, I extend the concept of behavior-based positive deviance research and interventions to the level of social systems.

Foucault generated his formulations of power without explicit consideration of systems of sexism, racism or classism; and so my use of Foucault in this project addressing public health practices targeting African American women requires explanation. Power systems, and their various interconnections, are critically important when considering African American women's experiences. I do not utilize Foucault's generalized theory of power to describe the particular experiences of African American women. Rather, I invoke Foucault to generate an understanding of how power operates that can be useful for public health practitioners when thinking about and developing health promotion strategies. Foucault has proved useful for feminists in a variety of

[5] The concept of "risk" is controversial in feminist and sociological discussions. For broad overviews, see Ulrich Beck's *Risk Society* and Nikolas Rose's *The Politics of Life Itself*. For a tailored discussion on the concept of risk in health promotion strategies see Robin Bunton, Sarah Nettleton and Roger Burrows' "The Sociology of Health Promotion."

endeavors.[6] Indeed, I was inspired to use Foucault after reading Mohanty's canonical "Under Western Eyes".[7] My project serves as a foundation for subsequent work that could draw on African American women's experiences for more specific insight into the power systems operating among particular groups of African American women.

It is also necessary to note two areas where language sometimes fails to convey my intentions. First, throughout the text I utilize Foucault's phrase "power systems" to describe the various networks through which power operates. When I use Foucault's phrase "power systems," I refer to the complex systems of racism, sexism, and classism that affect all African American women in the US. Notably, I am also referring to systems of heterosexism, ableism, and other named and unnamed power systems that impact the lives of African American women. I choose to use the all-encompassing phrase "power systems" to emphasize the plurality of local power systems within particular communities. Second, the language of race and gender almost always serves as prosthesis for the diversity inherent within racialized and gendered groups of people. Thus, the phrase "African American women" risks homogenizing the differences inherent within the population. When I employ the term "African American women" I am referring to a diverse group of people of various geographies, religions, sexualities, classes, etc. Within the text I specify when I am referring to a more specific subset of African American women.

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[6] For discussions of the usefulness of Foucault's theories for feminist analyses, see Susan Hekman's anthology *Feminist Interpretations of Foucault* and Margaret McLaren's *Feminism, Foucault, and Embodied Subjectivity*. These texts also provide specific examples of how feminists have used Foucault's theories, ranging from examinations of sexual violence and sexual harassment to explorations of some women's acquiescence to sexist standards of femininity.

[7] Mohanty's use of Foucault is described in Chapter 1.

Throughout this project, I am motivated by the principle that theory informs practice. An insightful conceptual framework is necessary for concentrated and effective practical strategies. In order to implement effective public health initiatives, public health practitioners must be steered by useful theories that adequately describe the dynamic interplay between identity, society and disease. As epidemiologist Nancy Krieger states, "clear action requires clear thinking" (Krieger 227). In this project I argue that many researchers could benefit from incorporating alternative notions of identity and social structure into their practice. Of course, I do not believe that these theories will solve all the methodological and theoretical problems associated with health disparity research. Instead, my arguments should serve as starting points for our continuous reflexive analysis of effective conceptual frameworks. The goal of this project is to encourage public health practitioners to reconsider their notions of identity and social structure when designing epidemiological methods and health promotion strategies. Through this theoretical work, we may be able to develop more effective strategies for reducing the growing burden of HIV/AIDS suffered by African American women. Moreover, the arguments outlined in this text extend beyond the HIV/AIDS epidemic among African American women. I hope that this project will impact health disparity research in general and inspire new approaches to addressing local and global health disparities.

Chapter 1:

Theories of Identity and Contextual Forces in Epidemiological Research

I begin this project with a textual analysis of how public health HIV/AIDS researchers conceptualize African American women's identities and the social structures in which they live. This chapter explores how these underlying understandings of identity and society may impact the design of public health research and interventions. My textual analysis involves an examination of public health review articles addressing the HIV/AIDS epidemic among African American women.[8] The first section of this chapter explores the two dominant frameworks for explaining African American women's disparate HIV infection rate: biomedical theories and behavioral theories. In the 1980s, public health researchers first explored the biomedical approach. However, after genetic theories were widely rejected and a biomedical cure for HIV/AIDS was not discovered, most researchers adopted individual-behavioral frameworks for thinking about HIV transmission. During the 1990s, these individualized approaches were critiqued for lacking a contextual understanding of African American women's lives. As a result, most researchers employed either cultural or structural explanations for African American women's increased engagement in high-risk behavior.

[8] My analysis represents an examination of 39 review articles addressing the epidemiology of HIV among African American women published between 1987 and 2008. Articles were located using a keyword-based search of PubMed and Web of Science. In PubMed, the keywords included a combination of "Black, women, HIV, AIDS" and the associated Medical Subject Heading (MeSH) terms, including "African Americans, female, acquired immunodeficiency syndrome." In Web of Science, the search text included "black women HIV AIDS, black women HIV AIDS epidemiology, African American women HIV AIDS, African American women HIV AIDS epidemiology." In both PubMed and Web of Science, the electronic filtering function was used to automatically restrict articles to review publications. Relevant articles were selected for analysis based on a review of each publication's title and abstract. Additional articles were also identified through the bibliographies of selected publications.

In the second section of this chapter, I explore two common assumptions of the cultural and structural frameworks that limit many public health research interventions into the growing HIV/AIDS epidemic among African American women. First, many public health researchers envision African American women as a unitary, static group situated within cultural and/or social structures. In "Under Western Eyes," Mohanty contends that theories of composite, stable identity constrain feminist analysis by concealing the processes by which identity is produced, and potentially transformed, *through* local power systems. Drawing on Mohanty's arguments, I argue that unitary, static conceptions of African American women situated within contextual structures limit public health research by overlooking the processes through which African American female identities are developed in local communities. The second analytic trap involves theorizing cultural and social structures as unyielding monoliths that determine African American women's behavior. In *The History of Sexuality*, Foucault argues that analyses based on centralized notions of power fail to comprehend the dynamic force relations within societies. Mohanty extends Foucault's argument by exploring how understanding power as a concentrated force limits feminist activism to generalized reactions instead of specific activism. Guided by Mohanty's understanding, I conclude by arguing that traditional conceptions of social structures limit public health practice by restricting intelligible interventions to abstract social transformation or limited, individualized behavior change.

Theoretical Frameworks Explaining the Disparate HIV Infection Rate among African American Women

Analysis of the review literature revealed two dominant understandings of the disparate HIV infection rate among African American women: the biomedical and the behavioral. The biomedical approach hypothesizes that biological differences between racial and sexual groups facilitate higher rates of HIV infection among African American women. By contrast, the behavioral theory postulates that African American women engage in behavior that places them at higher risk for acquiring HIV (e.g., unprotected sex or intravenous (IV) drug use). My analysis focuses on the behavioral framework, so it is worth contextualizing its historical emergence.

During the late 1980s, researchers first focused on biomedical explanations for African American women's higher susceptibility to HIV. For example, researchers explored race-based genetic risk factors during the early HIV epidemic. Three studies published in 1987 examined race-specific genetic factors, or "group specific components," that could increase the susceptibility of African Americans to HIV infection (Delange et al.; Eales et al.; Gilles et al.). However, by 1989 most researchers rejected the idea of race-based genetic susceptibility to HIV infection (Lewis and Watters 1071). Most of the genetic-based studies were undertaken in 1987, reflecting their priority in the scientific world – the majority of research on African Americans with HIV/AIDS was conducted after 1987.

The early public health focus on biomedical, and especially genetic, risk factors for HIV infection indicates an initial (albeit failed) attempt to view African Americans as a unitary identity group. By conducting research to identify biological, inborn characteristics that differ between social groups, many researchers relied on homogenous

notions of identity. This genetic research sought a genetic unity among African Americans that increased their susceptibility to HIV infection. Thus, this research indirectly aimed to define African Americans as a singular unit based on their shared genetics. However, the findings from these early studies did not support a genetic basis to African Americans' susceptibility to HIV. In the end, these studies failed to effect a genetically-based notion of African Americans' identity.[9] Nevertheless, their reliance on unitary notions of identity represents the first attempt to theorize African Americans' identity within HIV/AIDS disparity research. It is important to remember this legacy as public health practitioners explored alternative frameworks for explaining the disproportionately high HIV infection rate among African Americans and African American women in particular.

Despite initial efforts to understand African Americans' disparate HIV infection rate in terms of biomedical differences, no effective biomedical intervention or cure for HIV/AIDS was discovered. In response, public health researchers largely began focusing on behavioral approaches to explain and address the transmission of HIV (Lewis and Watters 1071).[10] The behavioral theories intend to explain why African American women engage in disproportionately high levels of drug-related and sexual behavior that increase their risk for HIV infection. These behavioral frameworks have come to dominate public

[9] For more discussion on the politics of genetics in race- and gender-based scientific research, see Anne Fausto-Sterling's "Refashioning Race," Dorothy Robert's "Is Race-Based Medicine Good for Us?," Myra Hird's *Sex, Gender, and Science* and Evelyn Fox Keller's *The Century of the Gene*.

[10] Some researchers have continued to utilize the biomedical framework for understanding the disparate HIV infection rate among African American women. However, the focus of the biomedical hypothesis has shifted to *acquired* biological risk factors. For example, infection with STIs has been shown to increase transmission of HIV (Johnson 23). According to the biomedical approach, the high prevalence of STIs among African Americans, particularly in the rural southern United States, facilitates the disproportionately high rate of HIV transmission among African Americans (Thomas S6). Although the acquired biological risk factors are formally addressed by the biomedical approach, they of course originate from behavioral risk factors (e.g., STI infection through risky sexual behavior).

health literature addressing HIV transmission among African American women. Within the behavioral framework, there are two main approaches. First, the individual-behavioral models analyze how and why African American women, as individuals, are motivated to engage (or not engage) in risky behavior. By contrast, the contextual-behavioral theories examine how sociocultural factors encourage (or discourage) behavior that places African American women at increased risk for HIV infection. These two behavioral themes are, of course, not mutually exclusive. In fact, many researchers advocate for interactive frameworks that consider the interplay between various theories. However, the interactive models most often maintain the integrity of each separate approach and simply combine them together into a meta-explanation. My analysis concentrates on each approach separately, investigating the premises of the various components of the interactive theories.

The individual-behavioral approach was most popular during the first two decades of the HIV/AIDS epidemic. This framework seeks to explain what motivates individuals to engage in behaviors that place them at risk for HIV infection. One theoretical model, titled the AIDS Risk Reduction Model (ARRM), epitomizes the individual-behavioral framework. Discussing the ARRM in "Strategies for Modifying Sexual Behavior for Primary and Secondary Prevention of HIV Disease," Thomas Coates writes, "The ARRM is based on the premise that to avoid disease, individuals must (a) perceive that their sexual behavior places them at risk for HIV infection, (b) reach a firm decision to make behavioral changes, and (c) take action" (65). As this model demonstrates, the individual-behavioral approach focuses on the individual's assessment of a situation, her/his

personal decision to engage in risky sexual behavior, and subsequent action based on the decision.

The individual-behavioral framework encompasses a variety of different theories.[11] In 1997, public health researchers Sally Zierler and Nancy Krieger summarized the main individual-behavioral theories employed to study HIV infection among women. Included among these were the behavioral/lifestyle model, psychological framework, health belief model, theory of reasoned action, social cognitive theory, and stages of change approaches (Zierler and Krieger 406-407). According to Zierler and Krieger, the behavioral/lifestyle approach explores how individuals' voluntary lifestyles impact susceptibility to disease. The psychological framework endeavors to determine the psychological motivations for adopting behavior that increases risk for disease transmission. According to the health belief model, "perceiving behavior as detrimental to health will motivate change" and "perception of personal susceptibility to disease, severity of disease, and social support influence [behavior] change" (Zierler and Krieger 407). The theory of reasoned action hypothesizes that one's intentions largely dictate her/his behavior. The social cognitive theory assumes that "health behavior is a function of social incentives" and that "perceived self-efficacy in affecting change influences behavior" (Zierler and Krieger 407). Finally, the stages of change approach contends that behavioral change is a predictable step-wise process that can be initiated through specific interventions.

Although the individual-behavioral framework includes many specific theories, all of them assume a completely rational subject. Specifically, these approaches

[11] Note that despite the differences between the individual-behavioral theories, they are all grounded in psychology. This reflects the dominance of psychology in many public health understandings of behavior.

concentrate on logical thought processes and how public health interventions can alter an individual's decision making. Public health researchers T. K. Logan, Jennifer Cole, and Carl Leukefeld write that the individual-behavioral "models are based on assumptions that individuals act rationally and within a cost-benefit analysis framework… and the models assume that freedom of choice for particular behaviors is available for all individuals at all times" (851). It is questionable whether these logic-based psychological theories are suitable for the heat of sexual negotiation or the psychological and physical addiction of drug abuse.

In addition to their reliance on a rational model of psychology, the individual-behavioral models do not pay adequate attention to cultural and/or structural influences on HIV transmission. Specifically, they imply that individuals are autonomous beings largely removed from sociocultural influences.[12] Wingood and DiClemente describe researchers' recognition of the myopia of the individual-behavioral approach in HIV/AIDS research on women:

> During the 1990s, researchers in the field of HIV prevention noted that most of the theoretical models driving this field had an individualistic conceptualization and did not consider the broader context of women's lives. These models assumed that the individual had total control over his or her behavior, and contextual factors, such as power differentials and gender roles that may heighten

[12] Some of the individual-behavioral frameworks do consider factors beyond the individual. For example, Zierler and Krieger note that the theory of reasoned action assumes that "social norms, attitudes, and perceived control affect intentions and influence change" (407). However, social cognitive theory aims to modify behavior by changing an individual's intentions, *not* by transforming "social norms [and] attitudes" (Zierler and Krieger 407). As this example demonstrates, even when individual-behavioral frameworks consider contextual factors they still focus on the individual and her/his thought processes.

> women's HIV risk, were given little attention. ("Application of the Theory of Gender and Power" 540)

The individual-behavioral frameworks lack adequate consideration of contextual influences that may increase African American women's risk for HIV infection. Furthermore, researchers recognized that successful public health interventions required consideration of sociocultural factors. Logan, Cole and Leukefeld write, "All behavior occurs within a host of social and contextual factors. Behavior change – especially sexual behavior change for women – is hindered without consideration of all of these factors" (852). During the 1990s, it became clear that an individualized, rationality-based psychological approach to understanding HIV epidemiology was insufficient.

As researchers recognized the limitations of individualized HIV prevention research, contextual approaches to understanding HIV epidemiology gained popularity.[13] These contextual-behavioral approaches hypothesize that sociocultural factors facilitate behavior that places African American women at higher risk for HIV infection. Within the contextual-behavioral framework, many researchers imagine that behavior is influenced either by "African American culture" or American social structure.[14]

The cultural approach seeks to explain how culture influences the disparate rate of HIV infection among African American women. For example, in "Women, HIV Infection, and AIDS," Michael Pizzi postulates that the African American (and Hispanic)

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[13] Although contextual HIV prevention research became more prevalent during the 1990s, some public health researchers were considering cultural and structural factors in HIV epidemiology at least as early as 1987 (Lester 387).

[14] As I discuss later, the concepts of "African American culture" and "American social structure" inaccurately assume a shared culture among all African Americans and one unitary American social structure.

cultural value of machismo facilitates high-risk behavior among heterosexual African Americans:

> Hispanic men, and many black men, are governed by the concept of machismo (e.g., being the one in control, the dominant one, the decision maker). This attitude often leads minority men to reject condom use. Because AIDS is increasing the fastest among these men, they unknowingly spread the disease to female partners. (1023)

Although Pizzi does not specify exactly how the concept of machismo "often leads minority men to reject condom use" (1023), he clearly hypothesizes that machismo within the African American community encourages unprotected heterosexual intercourse and places African American women at increased risk for HIV infection.[15] Similarly, in "Developing Strategies for AIDS Prevention Research with Black and Hispanic Drug Users," Robert Schilling et al. describe how African American women's lack of agency within African American culture facilitates risky sexual behavior. In a section titled "Cultural aspects of sexuality," Schilling et al. argue, "Interventions must be guided by an understanding of how gender issues and sexual attitudes and behaviors are anchored in culture… Too often, the burden of self-protection falls on women who have little power to insist on the use of condoms" (4). In this quotation, Schilling et al. contend that within "African American culture," African American women are held

[15] To make this claim, Pizzi draws on the scientific evidence that men have a lower chance of acquiring HIV compared to women during heterosexual vaginal sex (Pizzi 1021). Studies have also documented high rates of unprotected heterosexual anal intercourse among adolescent African American women, and anal intercourse is the "most effective means of HIV transmission from males to females" (Jaffe et al. 1005).

responsible for protecting themselves but are also disempowered. Schilling et al. imply that African American women's lack of power decreases their ability to negotiate condom use during heterosexual sex. In order to develop effective interventions, Schilling et al. argue that public health practitioners must understand these cultural "pathologies" within the African American community.

Although useful in its reframing of HIV/AIDS disparities from the individual to the contextual, the cultural framework ignores the impact of social structures on the experiences of African American women. The cultural approach hypothesizes that culture originates from a community of people largely removed from external structural environments. As Zierler and Krieger explain, this approach relies on the "conflation of 'culture' with sociopolitical conditions that force community and individual adaptation to discrimination and dehumanization" (416). Zierler and Krieger explain why this idea of culture removed from sociopolitical structures is not useful:

> First, it continues to hold accountable, solely, the 'communities' of African-American… people for the dangerous conditions in their lives, without mention of how these conditions have been shaped by white Euro-Americans; and second, it reinforces a legacy of scientific racism, promulgated by basic and social scientists, that there are inherent cultural norms that drive the racial/ethnic distribution of HIV as well as other damaging conditions. (416)

That is, the cultural framework myopically focuses on the "African American culture" and ignores sociopolitical structures that largely impact "culture" and, subsequently, disease transmission.

The cultural approach's erasure of sociopolitical influences on health disparities is exemplified in Wingood and DiClemente's "Cultural, Gender, and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents." In this article, Wingood and DiClemente report that "diverse cultural, psychosocial, and gender influences affect behavior" (381). Although they do explore these three factors, they almost always imply that the root cause of African American women's behavior is "cultural factors" within the "African-American community" (Wingood and DiClemente, "Cultural, Gender and Psychosocial Influences" 384). For example, some specific behavioral influences identified by Wingood and DiClemente include "the African-American family;… communication styles common among African-American youth;… and factors affecting self-efficacy, empowerment, and gender rules in the African-American female adolescent" ("Cultural, Gender and Psychosocial Influences" 381). Of all these factors, only self-efficacy was (partially) explained by "institutional inequality" (Wingood and DiClemente, "Cultural, Gender and Psychosocial Influences" 385). The remaining influences were implied to be "natural" realities of the African American community. Since "cultural" factors are thought to facilitate the disparate HIV infection rate, the cultural model risks focusing on the "African-American community" removed from larger sociopolitical structures.

In contrast to the cultural-behavioral theories, the structural-behavioral approach considers how social structures influence engagement in risk behavior. For example,

public health researchers Adaora Adimora, Victor Schoenbach, and Irene Doherty explore how social forces impact sexual behavior patterns among African Americans and, subsequently, the transmission of HIV:

> Socioeconomic forces such as racial discrimination, low ratios of men to women, and deprivation of economic opportunities… inhibit stable sexual partnering and increase the likelihood of concurrent partnerships and other network patterns that increase the spread of HIV… Taken together, these findings help explain the persistent and marked racial disparity in HIV/STI… (S44)

Adimora, Schoenbach, and Doherty also describe the specific pathways by which socioeconomic forces are thought to facilitate the high HIV infection rate among African American women.[16] They argue that racial discrimination leads to neighborhoods segregated by race and "effectively concentrates poverty and other adverse social and economic influences within the segregated group" (Adimora, Schoenbach, and Doherty S44). According to Adimora, Schoenbach, and Doherty, the poverty of many African American neighborhoods limits the number of "marriageable black men" (S43) and decreases the male-to-female sex ratio within African American communities. This low male-to-female sex ratio "places women at a disadvantage in negotiating and maintaining mutually monogamous relationships, because men can easily find another relationship if they perceive their primary one as problematic" (Adimora, Schoenbach, and Doherty S43). As a result, the "low sex ratio likely promotes concurrency and may also increase

[16] The next section of this chapter explores how the structural approach risks representing African American women as passive pawns of structural forces.

the likelihood of [sexual relationships] between low-risk women and men from high-risk subpopulations" (Adimora, Schoenbach, and Doherty S43-4). As this example demonstrates, the structural approach postulates that social forces facilitate the high HIV infection rate among African American women.

During the past three decades of public health research addressing the HIV/AIDS epidemic among African American women, the dominant research framework has shifted from a biomedical and individual-behavioral to a contextual-behavioral approach. Although the individual-behavioral approach is useful in explaining personal motivations for engaging in high-risk behavior, researchers rightfully criticized its use of rationality-based psychological theories and its inability to consider the impact of external forces on behavior. Without an understanding of how contextual factors affect behavior, these individualized approaches provided limited frameworks for understanding HIV epidemiology and for developing interventions. Recognizing the limitations of the individualized approach, the field has shifted to a contextual focus that examines the cultural and structural context of HIV transmission. However, in the next section I explore how during the shift from individualized to contextual frameworks, HIV/AIDS disparity research has fallen into two analytical traps.

Conceptions of Identity and Contextual Forces in the Cultural and Structural Theories

In this section, I explore two common assumptions in the contextual frameworks that limit both analysis and intervention into the disparate HIV infection rate among African American women. First, African American women are largely conceived of as a

unitary, static identity group situated within cultural and/or social structures. Second, cultural and social forces are imagined as centralized, all-powerful assemblies that shape African American women's behavior and the overall organization of society. It is important to note that the public health literature I reviewed is not homogenous in its methods or conclusions. This analysis does not claim to apply universally throughout the HIV/AIDS disparity literature. However, this analysis does seek to explain the *popular* understandings of African American women's identity and contextual forces and the subsequent *effects* of these assumptions.

Within the cultural framework, researchers often view African American women as a singular identity group situated within a uniform "African American culture."[17] Largely ignoring meaningful differences between African American women (e.g. geographic location, socioeconomic status, sexuality, etc.), these theories focus on the supposedly shared experiences of all African American women within "African American culture." For example, in Wingood and DiClemente's "Cultural, Gender, and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents," age is implied to be the only significant heterogeneity among African American women. Reviewing "psychosocial and cultural influences on behavior" ("Cultural, Gender, and Psychosocial Influences" 382), Wingood and DiClemente think of African American adolescents as one unit largely influenced by the "African American culture." In a section titled "The African-American family," Wingood and DiClemente write:

[17] I analyze the cultural framework's common simplistic and one-dimensional understanding of culture below.

> The African-American adolescent is surrounded by a kin organization of significant family influences that go beyond the nuclear family… The extended family often serves as the adolescent's main socializing agent and cultivates the adolescent's values of cooperation, unity, and communication skills. ("Cultural, Gender, and Psychosocial Influences" 383)

In this quotation, "the African-American adolescent" is thought to be a composite identity that experiences a similar "African American culture" regardless of class, sexuality, geography, etc. As this example shows, the cultural framework risks collapsing heterogeneity between African American women into a collective experience.

Some public health researchers have also critiqued the cultural framework's homogenization of African Americans. Discussing cultural approaches to HIV/AIDS disparity research, Zierler and Krieger write:

> To speak… of 'African-American,' 'Hispanic,' or less commonly 'white' or 'Anglo,' culture obscures large differences among people from different countries and from different regions within those countries (including the United States) and also reduces rich, complex, and heterogeneous histories, customs, and norms to a single experience. (416)

Zierler and Krieger argue that the cultural framework inaccurately assumes a shared cultural history among people of the same ethnic/racial group. Offering an alternative approach, they call for structural analysis that conceptualizes shared racial discrimination

as a unifying experience. They write, “What people in a subordinated racialized group do share… that has bearing on HIV risk is their membership in a racially oppressed group, although the history and structure of their oppression may differ” (Zierler and Krieger 416). From this premise, Zierler and Krieger advocate for the structural approach that analyzes how shared oppression influences high-risk behavior.

However, I argue that the structural approach also risks reducing African American women to one homogenous group. Unlike the cultural framework, which assumes sameness based on culture, the structural model posits shared oppression as a unifying factor. Mohanty discusses the limitations of such approaches for feminist analyses:

> [In many Western feminist writings,] what binds women together is a sociological notion of the ‘sameness’ of their oppression. It is at this point that an elision takes place between “women” as a discursively constructed group and “women” as material subjects of their own history. Thus, the discursively consensual homogeneity of “women” as a group is mistaken for the historically specific material reality of groups of women. (338)

Assuming unity within any racial/ethnic group erases meaningful differences within the population. This also holds true for structural frameworks that assume unity based on shared oppression.

The homogenization of ethnic/racial groups through structural analysis is exemplified in William Wolfe’s “Overlooked Role of African-American Males’

Hypermasculinity in the Epidemic of Unintended Pregnancies and HIV/AIDS Cases with Young African-American Women." In this article, Wolfe thinks of African American males as a unitary, hypermasculine group. Wolfe argues that this hypermasculinity is rooted in discrimination against African American males:

> The [hypermasculinity of African-American males] revolves around the effects of racism and the ways it has made it more difficult for African-American males to achieve a masculine self-identity through the conventional routes of work and the assumption of family responsibilities. (848)

Without a positive self-identity, African American males are thought to overcompensate by adopting "a manipulative and exploitative attitude with African-American women" (Wolfe 848). Wolfe suggests that this attitude among African American males encourages multiple female sex partners, thereby facilitating HIV transmission. This example highlights how racism, a sociopolitical force, is employed to theorize a unified African American male identity.

Feminist scholars have argued that the conception of social identity groups as composite, stable categories limits feminist scholarship and practice. In "Under Western Eyes," Mohanty argues that stable, uniform formulations of identity limit feminist analysis and activism by concealing the production of identity *through* power systems. [18] Writing about Western feminist analyses of third world women, Mohanty states, "Western feminist discourse, by assuming women as a coherent, already constituted

[18] Mohanty's emphasis on identity production through power systems obscures the co-constitutive nature of individuals, identity, and power systems. For the present discussion, I concentrate on the production of identity through power systems in order to focus my argument.

group… defines third world women as subjects *outside* social relations, instead of looking at the way women are constituted *through* these very structures" (351). Framing third world women as a composite group situated within social structures relies on static, unitary notions of identity. According to Mohanty, these theories of identity provide limited "explanatory potential" because they fail to consider the complex historical and social processes through which identity becomes intelligible (336). Without analysis of identity production through local power systems, feminists overlook the "historically specific material reality of groups of women" (Mohanty 338).

Similarly, the conceptualization of African American women as a composite, static group in HIV epidemiological research limits analytic insight and frameworks for intervention. By assuming that African American women are an always-already existing category before conducting research, public health practitioners fail to recognize the complex power systems that produce specific African American female identities. Without careful analysis of how a particular group of African American women's identities are produced through cultural and social systems, we fail to uncover specific circumstances that facilitate HIV transmission within local communities. Subsequently, interventions are developed according to generalized notions of "the" African American woman without insight into the particular identities of African American women within a local context. My analysis is therefore not so much against generalizations of African American women as it is more so in favor of "careful, historically specific complex generalizations" (Mohanty 349).

The importance of recognizing differences between African Americans has been articulated by many US Black feminist theorists. In her influential "Black Feminist

Thought," Patricia Hill Collins documents one of the main themes of US Black feminist thought:

> All African-American women face similar challenges that result from living in a society that historically and routinely derogates women of African descent. Despite the fact that U.S. Black women face common challenges, this neither means that individual African-American women have all had the same experiences nor that we agree on the significance of our varying experiences. (25)

The plurality of African American women's experiences renders inaccurate any attempt to understand African American women's lives through the experiences of one quintessential African American woman. As Collins states, "There is no essential or archetypal Black woman whose experiences stand as normal, normative, and thereby authentic" (28). Building upon this insight, Black feminist scholars have also highlighted the practical limitations of singular notions of African American women. Perhaps the most prominent scholar in this area is Audre Lorde. In her well known "Age, Race, Class, and Sex: Women Redefining Difference," Lorde argues that "refusing to recognize difference makes it impossible to see the different problems and pitfalls facing us as women" (287). Lorde specifically points to differences between African American women based on sexuality, age, and class. Recognizing these differences, and African American women's various life experiences, is important when trying to identify the various causes of HIV infection among different groups of African American women.

Moreover, I am not just advocating for more specific, local analyses of HIV epidemiology among African American women. I am also suggesting that assuming identity as a pre-given fact inhibits us from asking critical questions about HIV transmission. Traditionally, many public health practitioners assume that African American women compose one static group and conduct research to examine their risk factors for HIV infection. After identifying these risk factors, most researchers analyze "African American women's lives" to understand why they disproportionately engage in risk behavior. Subsequent interventions are then limited to changing these risk factors, without adequate consideration of their underlying causes. This mode of analysis and intervention inhibits insight into how particular African American women's identities are constructed through contextual forces and how this particular identity development contributes to HIV transmission. African American women do not simply exist within contextual forces; rather, their identities (and indeed all identities) are produced through various power systems. Recognizing identity production through power systems enables researchers to identify how identity-based risk factors are *generated*. It is this analysis that can guide us toward effective interventions that interrupt the adoption of risk behaviors during the construction of particular identities.[19]

In addition to this first analytic trap, the vast majority of public health research also perceives contextual structures as vast, unqualified forces. Within the cultural approach, researchers often imagine "African American culture" to be an ever-present, totalizing arrangement that determines the behaviors of African American women.

[19] See Chapters 2 and 3 for further discussion on the generation of risk factors through the production of identity within local power systems.

Similarly, the structural approach largely imagines social structures, such as racism and sexism, as domineering arrangements.

The cultural approach risks theorizing African American women as passively situated within a one-dimensional, all-powerful "African American culture." This frequently occurs when researchers cite particular statistics and subsequently explain them in terms of culture. For instance, Logan, Cole and Leukefeld state that African American culture "tend[s] to hold traditional and conservative attitudes toward gender roles, including acceptance of a greater level of sexual promiscuity for men and boys" (852). To explain this claim, Logan et al. provide examples of research studies that report higher rates of sexual intercourse (including extramarital) among African Americans compared to Caucasians. However, Logan Cole and Leukefeld do not explicitly describe how "African American culture" is linked to these statistics. For instance, they do not postulate that the influence of traditional Christian thought in certain African American cultures can perpetuate traditional gender roles and the exploitation of women.[20] Instead, the omnipotent "African American culture" is simply implied as the causative agent of risky behavior.

Similarly, the structural framework often thinks of African American women as existing within a singular and omnipotent social structure. For example, many public health researchers hypothesize that sexism and racism, as totalizing sociopolitical forces, are largely responsible for the disparate HIV infection rate among African American

[20] The influence of Christian African American churches on the lives of many African Americans remains strong. Recent estimates suggest that there are 65,000 to 75,000 majority African American congregations in the US (Billingsley and Caldwell 432). The major historic African American denominations include the African Methodist Episcopal, African Methodist Episcopal Zion, Christian Methodist Episcopal, Church of God in Christ, National Baptist Convention – USA, Inc., National Baptist Convention of America, and the Progressive National Baptist Convention (Billingsley and Caldwell 430). For more information on the problematic perpetuation of gender roles in some Christian traditions, see Renita Weems' *Battered Love*.

women. Discussing the role of sexism in HIV epidemiology among women, Wingood and DiClemente argue that the "gender–based inequities and disparities in expectations… generate the exposure… and the risk factors that adversely influence women's health" ("Application of the Theory of Gender and Power" 541). Specifically, Wingood and DiClemente suggest that the "sexual division of labor" (e.g., women have less socioeconomic resources than men), the "sexual division of power" (e.g., women lack power in heterosexual relationships), and "social norms and affective attachments" (e.g., cultural norms encourage female disempowerment) facilitate HIV transmission among women (particularly African American women) ("Application of the Theory of Gender and Power" 542-544). In all of these theories, sexism is depicted as one vast, all-powerful institution that controls not only the behaviors of people but also the organization of society.[21]

What is significant in these understandings of culture and social systems is the ownership of power by one-dimensional contextual forces. The public health literature largely implies that a homogenous culture and sociopolitical structure possess absolute power and produce totalizing effects on African American women and men. Within this system, African Americans are largely represented as victims and pawns of contextual environments. Chapter 3 will explore how one-dimensional notions of victimization impact the public health response to the HIV/AIDS epidemic among African American women. In the last part of this chapter, I focus on how understanding African American

[21] For projects that operate with the same presumptions, see Adimora, Schoenbach and Doherty's "HIV and African Americans in the Southern United States," Aral, O'Leary and Baker's "Sexually Transmitted Infections and HIV in the Southern United States," and Logan, Cole and Leukefeld's "Women, Sex, and HIV."

women as hostages of contextual forces affects theoretical frameworks for intervening into the epidemic.

Mohanty's "Under Western Eyes" argues that the problematic assumption of unitary, static identity is not only analytically limiting by itself, but that is also relies on understandings of possessional power that further restrict analysis. Writing about Western feminist writings on third world women, Mohanty states, "Feminist discourse on the third world which assumes a homogenous category – or group – called women necessarily operates through the setting up of originary power divisions" (350). Mohanty then draws on Foucault's elucidation of power to explicate the limitations of thinking about power in terms of ownership. In *The History of Sexuality*, Foucault argues that analyses based on power should not assume that power is a possession passed from one person to another. For Foucault, power is not an entity that can be acquired or possessed by people, institutions, etc. Instead, power is a plurality of force relations that form complex systems:

> It seems to me that power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; … [and] as the strategies in which they take effect, whose general design or institutional crystallization is embodied… in the various social hegemonies. (Foucault, *The History of Sexuality* 92)

According to Foucault, power is executed through relational forces.[22] If force relations accumulate and reinforce each other, they can produce the illusion of institutions and/or groups of people "possessing" power. When conducting analyses of power, however, Foucault warns that power "must not be sought in the primary existence of a central point, in a unique source of sovereignty from which secondary and descendent forms would emanate" (*The History of Sexuality* 93). Moreover, one should not assume that "the over-all unity of a domination [is] given at the outset" (Foucault, *The History of Sexuality* 92). Indeed, Foucault argues that states of power are "always local and unstable" (*The History of Sexuality* 93). Analyses based on power, therefore, should identify the specific modes in which power is executed instead of assuming a united, omnipotent power structure.

By assuming that structures possess unyielding power that shapes institutions, human relations, etc., public health researchers lose analytic insight into the specific modes through which power is executed. Once a totalizing notion of power relations within "African American culture" or American social structure is established, researchers are theoretically limited to simply identify the "secondary and descendant forms" (Foucault, *The History of Sexuality* 93) of power (such as racist and sexist institutions) and hypothesize how they facilitate the disparate HIV infection rate. However, this process restricts analysis to the "institutional crystallization[s]" (Foucault, *The History of Sexuality* 93) of force relations and overlooks how the specific, relational modes of power contribute to HIV transmission. By conducting careful, localized analysis of force relations, public health researchers can identify the specific, reinforcing

[22] This theory of power highlights the co-constitutive nature of individuals and power systems: individuals are involved in the generation of power systems and are also created by them.

processes that facilitate the disproportionate HIV infection rate among African American women. For example, public health practitioners could research the specific processes within local communities that lead to homelessness, engagement in drug injecting practices, unprotected sex, or other risk factors for HIV infection.[23] Incorporating Foucault's notion of power into research encourages public health practitioners to not simply theorize how omnipotent contextual forces affect HIV transmission, but to identify the specific processes through which power is exerted in local communities and the subsequent effects on HIV epidemiology.[24]

Furthermore, thinking about contextual forces as all-powerful structures fails to provide specific strategies for change. Discussing Western feminist writings on third world women, Mohanty argues that omnipotent notions of power structures restrict change to unguided, generalized reaction. Writing about binary power relations, Mohanty argues:

> Power relations are structured in terms of a source of power and a cumulative reaction to power. Opposition is a generalized phenomenon created as a response to power… The major problem with such a definition of power is that it locks all revolutionary struggles into binary structure – possessing power versus being powerless. (350)

[23] For an example of a research study that examines specific housing situations that can increase HIV risk among a particular community of African American women, see Quinn Gentry, Kirk Elifson, and Claire Sterk's "Aiming for More Relevant HIV Risk Reduction."

[24] Chapter 3 provides a more specific approach to researching and intervening into the HIV/AIDS epidemic among African American women.

Binary conceptions of power limit transformation to a "generalized phenomenon" (Mohanty 350) without specific frameworks for change. In particular, these notions of power fail to theorize how the "powerless" can change the "powerful" structures.

Consequently, traditional understandings of contextual forces fail to offer a framework for the development of effective public health interventions. I argue that conceptualizing "African American culture" and social structures as unitary, all-powerful forces restricts theoretical blueprints for intervention to the abstract transformation of culture and/or social structure or the limited targeting of individual African American women's behaviors. According to the contextual hypotheses, the disparate rate of HIV infection among African American women results either from a pathological "African American culture" or oppressive power structures. The first and most obvious type of public health interventions derived from these theories is the transformation of culture and/or power systems. However, if culture and power structures are imagined as all-powerful monoliths, the theories do not provide useful frameworks for interventions. The critical question remains unanswered: *how* do we change culture and/or power structures given their conceptual omnipotence? A first step to avoiding this analytic trap is to highlight the plurality and dynamic nature of culture and social systems. Indeed, there is no one "African American culture;" rather, African Americans co-identify with various groups and cultures (see Vetta Sanders Thompson's "The Complexity of African American Racial Identification" and Clifford Broman, Harold Neighbors, and James Jackson's "Racial Group Identification among Black Adults"). Furthermore, cultures and social structures are always in flux, and thus there will never be one "African American culture" or "American social structure" to target for an intervention. Even after

recognizing the diversity and flux of contextual forces, the notion that these contextual forces possess unqualified power still limits blueprints for effective public health promotion strategies. The interventions, after all, must still change omnipotent cultures and social structures.[25]

As a second type of intervention, the contextual approach suggests targeted, individual behavior change. An understanding of African American women as situated within a domineering and unitary power structure suggests that behavior modification requires specific attention to individuals: concentrated, focused attention to individual behavior change would be required to combat the ubiquitous culture and/or power structure in which African American women live. However, the contextual hypotheses lack theoretical understandings of successful, personalized behavior-based interventions. In particular, how can we change behavior through public health interventions (not to mention while maintaining cost-effectiveness) given that African American women are exposed daily to pervasive "African American culture" or a racist and sexist social structure? As explored in the following chapters, racist and sexist power systems impact African American women in varying ways. For instance, power systems largely characterized by racist sexism may primarily affect African American women based on their sexuality and then add a component specific to their race. Similarly, power systems largely characterized by sexist racism may primarily racialize African American women and then add a factor specific to their sexuality. The concepts of racist sexism and sexist racism are helpful in emphasizing the interaction of various social systems in different situations. They also highlight the conflation of power systems in specific environments:

[25] The next chapter explores how Foucault's theory of power offers a framework for conceptualizing effective interventions that target contextual environments within specific communities.

in both racist sexism and sexist racism, racist and sexist power systems operate together, though in varying degrees. Moreover, there are many other power systems that affect specific populations of African American women. By thinking of African Americans as totalized pawns of singular contextual environments, public health practitioners fail to think about how African American women's daily realities are produced through specific force relations. For example, how do local systems of employment, education, sex exploitation, etc. affect the lived experiences of certain groups of African American women? Without this insight, public health understandings of African American women's disproportionate rate of HIV infection lack effective strategies for intervention.

This chapter has demonstrated how notions of identity and contextual forces are critical for not only explaining identity-based health disparities but also for creating and implementing public health interventions. I have argued that traditional notions of contextual environments limit frameworks for intervention to the intangible transformation of culture and/or social structure or the modification of individual African American women's behaviors. However, a critical question remains: does this theoretical limitation translate into a practical problem? Have traditional notions of social structure restricted the existent interventions developed by public health researchers? This is the focus of the next chapter.

Chapter 2:

Conceptual Frameworks for Structural Interventions

In the previous chapter, I argued that traditional conceptions of power in HIV/AIDS epidemiological research limit public health interventions. Specifically, the epidemiological literature largely conceives of contextual forces as possessing unyielding power that organizes human dynamics. This theoretical model restricts intelligible interventions to abstract social transformation or limited, individualized behavior change. In this chapter, I explore how conventional epidemiological understandings have restricted the actual interventions implemented by public health practitioners. In the first section, I analyze many existing HIV prevention strategies that address HIV/AIDS among African American women. My findings demonstrate that most HIV interventions utilize individualized behavioral approaches. Despite epidemiological research indicating that structural factors shape African American women's disproportionate HIV infection rate, public health practitioners have implemented very few structural interventions. In the second section, I review common explanations for the lack of structural HIV prevention strategies. Building upon my analysis in the first chapter, I argue that traditional conceptions of social structure do not provide conceptual frameworks for sustainable structural interventions. If we want public health prevention strategies to shift toward structural approaches, we must first elucidate how structural interventions promote lasting effects on behavior. I conclude by exploring how Foucault's formulation of power and Mohanty's conception of identity production

provide a foundation for theorizing sustainable behavioral change through structural HIV prevention programs.

To examine the common interventions addressing the HIV/AIDS epidemic among African American women, I reviewed research interventions published in the public health literature.[26] HIV research interventions involve both the implementation and evaluation of HIV prevention strategies. Most conduct pre- and post-intervention measurements so that researchers can assess the impact of the intervention on HIV transmission and/or the prevalence of risk factors associated with HIV infection. The results of research interventions are published in academic journals in order to assist other researchers in the development of effective prevention strategies and health policies. By reviewing published research interventions, I aimed to understand the common public health approaches to HIV prevention among African American women.

Dominant Intervention Approaches Addressing the HIV/AIDS Epidemic among African American Women

Analysis of the review literature revealed two primary approaches to interventions addressing the disproportionate HIV infection rate among African American women: the

[26] My analysis represents an examination of 30 review articles from 1987 to 2009 that summarize and/or analyze public health interventions that address the HIV/AIDS epidemic among African American women. Articles were identified by an electronic search of PubMed and Web of Science. In PubMed, search terms included a combination of "black women HIV AIDS prevention control" and the associated Medical Subject Heading (MeSH) terms, including "African Americans, female, acquired immunodeficiency syndrome." In Web of Science, the search text included a combination of "black women HIV AIDS prevention control" and "African American women HIV AIDS prevention control." In both PubMed and Web of Science, articles were restricted to review publications through the automatic filtering function provided by the search engine. Relevant articles were selected for analysis based on a review of each publication's title and abstract. Additional articles were also identified through the bibliographies of selected publications.

individual and the structural.[27] The individual strategy tries to reduce individual African American women's biomedical and behavioral risks for HIV transmission. By contrast, the structural approach promotes environmental and social structures that facilitate a decrease in high-risk behavior among African American women. Structural approaches are represented in the literature, but individualized interventions have undoubtedly dominated the public health response to the HIV epidemic.

Within the individual approach, interventions can be further divided into the individual-biomedical and the individual-behavioral strategies. Whereas the biomedical method attempts to optimize African American women's biomedical barriers against HIV transmission, behavioral interventions intend to reduce high-risk personal behavior that facilitates HIV infection. However, both strategies share the overarching goal of reducing individual risk factors for HIV transmission among African American women.

To reduce the individual-biomedical risks of HIV transmission among African American women, public health researchers have implemented two main strategies: the treatment of existing sexually transmitted infections (STIs) and the appropriate care of HIV-infected pregnant women.[28] Treating existing STIs among African American women is an important intervention because infection with most STIs increases the transmissibility of HIV (Berman and Cohen S50). This biomedical strategy is particularly

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[27] Public health researchers have implemented other types of interventions, including strategies that focus on sexually intimate couples, peer networks, and neighborhoods. These types of interventions were not included in most of the review articles. However, many of the components of these interventions can be understood in terms of the individual and structural frameworks.

[28] Another common biomedical strategy is the development of microbicides, chemical products that can be applied topically to prevent HIV transmission. As one medical researcher notes, "Microbicides… may offer one of the most promising preventive interventions, because they could be inexpensive, readily available, and widely acceptable" (Hillier et al. 1). Furthermore, microbicides represent a woman-controlled prevention strategy that does not necessarily require cooperation from males during heterosexual intercourse. However, researchers have not developed effective microbicides that prevent HIV transmission (Hendrix, Cao and Fuchs 349). As a result, microbicides have not been incorporated into intervention research.

relevant for African Americans since STI prevalence is relatively high among this population (Barrow et al. S30). As public health practitioners Stuart Berman and Myron Cohen argue, “Since rates of STDs and HIV are both disproportionately high among blacks, it is particularly relevant to consider how control and treatment of STDs can contribute to prevention of HIV” (S50). Similarly, there are a number of strategies to decrease the transmission of HIV from mother to child. Specifically, clinicians can decrease the perinatal HIV transmission rate by reducing women’s HIV viral load during pregnancy with chemoprophylaxis, conducting cesarean sections, and counseling HIV-infected mothers to avoid breastfeeding (Mofenson 7). These interventions are particularly important for African American women since mother-to-child HIV transmission is highest among African Americans compared to all other ethnic groups (CDC, “Mother-to-Child” 1).

In contrast to the biomedical interventions, the individual-behavioral strategies utilize instructional workshops to minimize risky sexual and injecting drug use behavior. These interventions usually involve anywhere from one to sixteen workshops for a total of one to thirty-two hours (Logan, Cole and Leukefeld 861; Lyles et al. 135). The sessions take place in various settings including health clinics, community centers, educational and research institutions, and correctional facilities (Semaan et al. S38; Darbes et al. 1179). Based on the structure of the workshops, the individual-behavioral approach can be further classified as individual, group or community (Lyles et al. 134). Within the individual framework, trained specialists deliver interventions to individuals alone. Group interventions utilize small group discussions and group-oriented activities. Community approaches offer services and workshops to a larger community without

delineating particular groups within the community. Despite their different structures, all three of these sub-categories are defined as individual-behavioral approaches because they concentrate on motivating individuals to adopt safer sexual and injecting drug use practices (Semaan et al. S49).

The majority of individual-behavioral interventions rely on behavioral change models (Logan, Cole, and Leukefeld 851; Semaan et al. S33; Albarracin et al. 857-8; Lyles et al. 135; Darbes et al. 1179; Noar, Black and Pierce 111). The most general framework that encompasses the various behavioral change theories is the information-motivation-behavioral skills (IMB) model (Albarracin et al. 858). This model suggests that behavior can be predicted based on the quality and quantity of someone's knowledge, motivation, and behavioral skills.[29] Psychologist Dolores Albarracin et al. describe the three specific components of the IMB model:

> An informational communication typically conveys structured data on the nature of HIV, modes of transmission, mechanisms of the disease, and methods of prevention… Motivational interventions attempt to induce favorable attitudes as well as social norms in support of the behavior and perceived vulnerability to HIV, typically combining… the theories of reasoned action and planned behavior… According to the information-motivation-behavioral skills model, however, HIV-prevention programs are generally not successful unless they manage to increase behavioral skills as well. Thus, interventions based on this

[29] The limitations of psychological models that only consider rationality, such as the IMB framework, are discussed in Chapter 1.

> model often contain behavioral scripts about strategies that yield successful performance of the behavior. (858)

Most of the individual-behavioral interventions utilize theories encompassed within the IMB model. Informed by these theories, the individual-behavioral HIV prevention programs utilize a combination of five main strategies to facilitate the adoption of safe sexual and injecting drug use practices: transmitting knowledge, increasing motivation to engage in safe behavior, developing skills, providing support, and distributing supplies necessary for risk reduction.

Guided by the information theory within the IMB framework and related models, practically all of the individual-behavioral workshops teach participants about HIV transmission and risk reduction strategies (e.g., condom use, cleaning needles, abstinence). This is most frequently accomplished by distributing printed materials and by conducting personalized HIV counseling (Smoak et al. 376). Additional teaching strategies include lectures on STD epidemiology and prevention, facilitated small group discussions, interactive computer and Internet programs, and instructional videos (Mize et al. 176-80; Noar, Black and Pierce 110).

To motivate behavior change, individual-behavioral interventions often utilize positive and/or negative motivational strategies. The positive approaches stress the benefits of safe behavior and hope to convince intervention participants that they are capable of adopting safer practices (Albarracin et al. 858). Within this category, workshops try to increase individuals' perceived self-efficacy and sense of responsibility to maintain their health and the health of others (Semaan et al. S34; Darbes et al. 1186).

By contrast, negative motivation strategies concentrate on the negative consequences of risky behavior (Albarracin et al. 858). Workshops using this approach work to increase participants' perceived risk of HIV infection and highlight the severity of HIV/AIDS (Albarracin et al. 858; Darbes et al. 1181).[30]

According to the IMB model, information and motivation are insufficient to inspire behavior change; interventions must also teach the specific behavioral skills required for the adoption of safe practices. To this end, many researchers endeavor to enhance the personal, interpersonal, and technical skills African American women will need for risk reduction (Lyles et al. 135). To promote personal skills (e.g., decision-making, goal setting, risk identification, attitude training, self-esteem enhancement, stress management), researchers often conduct self-management trainings (Mize et al. 179; Smoak et al. 376; Lyles et al. 135; Darbes et al. 1181). Interventions teach risk-reducing interpersonal skills (e.g., assertive communication, condom and safe-needle negotiation, and sexual refusal) through workshops and role-playing exercises (Mize et al. 175-176). Finally, researchers frequently teach technical skills on needle cleaning and condom use through didactic demonstrations and rehearsals (Mize et al. 175-9; Lyles et al. 135).

In addition to the three main components of the IMB model, many public health practitioners recognize that mentally and physically healthy individuals with adequate resources are most likely to adopt safer behavior. Thus, many individual-behavioral interventions also offer support services and provide supplies required for risk-reduction. Support services include referrals to external agencies that provide resources unavailable to the researchers (e.g., referrals to drug rehabilitation facilities, STD clinics), counseling

[30] Albarracin et al. found that positive approaches were more successful than negative motivation strategies (867).

and emotional support services, empowerment exercises, education on additional community resources, and encouragement of social support (Mize et al. 178; Neumann et al. S110; Lyles et al. 135; Darbes et al. 1186). Some interventions collaborate directly with other support services including domestic violence shelters for women, substance abuse rehabilitation centers, and STD screening clinics (Logan, Cole and Leukefeld 865-7). In addition, researchers often provide the resources necessary to directly reduce the risk of HIV transmission, including condoms and clean needles for injecting drug use (Mize et al. 176; Neumann et al. S110).

By focusing on individuals and their immediate resources, the individual-behavioral interventions often ignore the larger contextual factors that affect African American women's risk for HIV infection. During the 1990s and early 2000s, many public health practitioners criticized such interventions for failing to recognize the social forces that inhibit women from adopting safer practices (Amaro and Raj 724). For example, in "Prevention of HIV Infection in Women," public health practitioners Mary Guinan and Laura Leviton identify the limitations of individualized behavioral interventions. They argue that traditional approaches to (hetero)sexual behavior change do not adequately consider "gender role expectations that may vary among racial/ethnic populations [and] unequal power relationships between men and women in sexual decision making" (Guinan and Leviton 75). Similarly, Guinan and Leviton contend that interventions designed for injecting drug users (IDUs) lack consideration of the "unique cultural, social, and legal influences on women IDUs [that] may prevent entry into and successful completion of substance abuse programs" (75). Presently, most public health

practitioners agree that individual-behavioral HIV prevention programs need to consider broader social influences on behavior.[31]

In response to the criticism that individualized interventions fail to consider larger contextual factors, interventionists developed culturally competent approaches that sought to address specific cultural and social conditions that affect African American women's risk for HIV infection. Writing in 2002, Mize et al. describe the emergence of this culturally sensitive approach:

> It is becoming increasingly apparent that HIV prevention interventions need to be sensitive to cultural issues. Numerous authors have recommended the use of culturally specific interventions to increase the relevance of their content and their subsequent effectiveness among specific populations. (164)

One goal of culturally competent interventions is to utilize educational strategies that are relevant to African American women. Interventionists often design "ethnicity-specific pamphlets describing AIDS resources," utilize "rap video[s] containing HIV/AIDS info," or employ presenters of the same ethnicity as the target audience (Mize et al. 164-80). Another primary aim of culturally sensitive approaches is to empower African American women and to teach them strategies for navigating potentially dangerous contextual forces. For example, some public health practitioners incorporate "racial/ethnic pride" workshops and others conduct exercises that address "social/cultural and gender barriers" to behavior change (Mize et al. 164). Similarly, some interventions try to increase

[31] Individual-behavioral workshops do generate a certain kind of sociality, and even objects can produce sociality (see Nicole Vitellone's "The Syringe as a Prosthetic"). However, they do not *focus* on the broader societal impact on behavior.

African American women's ability to cope with traumatic experiences (Logan, Cole and Leukefeld 870). To increase the cultural specificity of health promotion materials and strategies, some interventionists also conduct research on the target population (Albarracin et al. 859). This research draws on the understanding that there are diverse cultures within any one "population" and that the most effective culturally competent approaches will be targeted to specific cultures.

Although the culturally sensitive individual-behavioral approach addresses contextual factors in African American women's lives, it is limited by an inability to address social and cultural forces (or, indeed to adequately conceptualize the co-constitutive relation between social and individual forces). The individual-behavioral interventions have shown some success in reducing risky practices and, subsequently, incidence rates of HIV and other STIs (Mize et al. 163; Neumann et al. S106; Smoak et al. 374; Lyles et al. 133; Darbes et al. 1177; Noar, Black and Pierce 107). However, research indicates that the effects of these interventions usually decrease over time (Logan, Cole and Leukefeld 871). Furthermore, many public health practitioners have recently argued that individual-behavioral approaches alone are insufficient because they do not change the underlying root causes of risky behavior within particular communities. As psychologist Geeta Rao Gupta et al. state, "HIV prevention efforts cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings" (764). Based on this understanding, researchers have recently pursued interventions that disrupt the underlying contextual causes of HIV transmission.

In contrast to the individual framework, the structural HIV prevention approach hopes to establish contextual environments that encourage the adoption of safe sexual and injecting drug use behaviors. Structural factors that can facilitate or inhibit HIV transmission include "physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment" (Gupta et al. 765). From a structural perspective, interventions should alter structural factors that facilitate HIV transmission and they should create environments that promote low-risk behaviors.

Structural interventions targeting African Americans can be classified as policy/legal, economic, and physical.[32] Policy/legal strategies strive for legal reform that promotes the reduction of risky HIV practices. One policy-based legal intervention involves the distribution of clean needles and syringes (Gupta et al. 766). This approach supports policies that legalize the possession or dissemination of drug-related paraphernalia. The primary goal of this intervention is to increase the availability of safe injecting drug use equipment and, subsequently, to decrease the rate of drug injecting practices that facilitate HIV transmission.[33] Similarly, economic structural approaches intend to prevent risky behavior associated with low income. For example, project JEWEL (Jewelry Education for Women Empowering Their Lives) taught a group of illicit drug-using sex workers how to produce and sell jewelry (Sherman et al. 1). The JEWEL researchers aimed to reduce the frequency of illicit drug use and prostitution by providing an alternative source of income and recreation (Barrow et al. S36). Finally, the physical structural framework recognizes that one's physical environment can promote

[32] For further information on HIV structural interventions targeting groups other than African Americans, see "Structural Approaches to HIV Prevention" by Gupta et al.

[33] As with most of the individual-behavioral interventions, this structural intervention assumes a kind of rationality in which all people will use (or be able to use) clean syringes if available.

risky behavior. One physical structural intervention, presented in "Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV," endeavors to address previous research indicating an association between HIV transmission and homelessness (Kidder et al. S150). To decrease practices promoting HIV transmission that are associated with homelessness, Kidder et al. provided rental housing to homeless persons living with HIV/AIDS.

During my review of the public health literature, what was most striking was the overwhelming lack of structural approaches to HIV prevention. This finding is substantiated by several reviews of HIV interventions targeting African American women and other populations (Neumann et al. S114; Darbes et al. 1192; Friedman, Cooper and Osborne 1002). Writing in 2008, Gupta et al. explain that HIV prevention research has largely concentrated on individual-behavioral frameworks:

> For the past two and a half decades, HIV prevention has been dominated by individual-level behavioural interventions that seek to influence knowledge, attitudes, and behaviours, such as promotion of condom use, or sexual-health education, and education of injecting drug users about the dangers of sharing equipment. (764)

Interestingly, individual-behavioral interventions have dominated HIV prevention strategies despite researchers' recognition since the late 1980s that "contextual" factors can facilitate HIV transmission (Lester 387). In the following section, I explore current

explanations for the lack of structural interventions and I propose a conceptual framework that can facilitate the development of structural HIV prevention strategies.

Obstacles and Solutions for Public Health Investment in Structural Interventions Addressing the HIV/AIDS Epidemic among African American Women

There is a clear disconnect between epidemiological understandings of HIV/AIDS disparities and the existent interventions designed to decrease HIV transmission among African American women.[34] In the previous chapter, I documented the conventional understanding that cultural and social structures facilitate African American women's disproportionate rate of HIV infection. However, only a handful of structural interventions that directly address contextual factors exist in the public health literature. Public health practitioners have offered two main explanations for this dearth of structural HIV prevention strategies: a lack of methodological clarity and a conviction that broader contextual forces are beyond the influence of public health interventions. Some researchers propose that these obstacles can be avoided by adopting a different understanding of social disease transmission, the causal-pathway theory. However, I contend that the causal-pathway model also fails to elucidate how structural interventions can create lasting public health improvements.

One of the commonly accepted reasons for the lack of structural HIV prevention strategies is a "lack of conceptual and technical consensus on [the] definition and

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[34] In "Women, Sex, and HIV: Social and Contextual Factors, Meta-Analysis of Published Interventions, and Implications for Practice and Research," Logan, Cole and Leukefeld identify specific gaps between contextual explanations for the disproportionate rate of HIV infection among women and corresponding structural interventions (869).

implementation" of structural interventions (Gupta et al. 764). Logan, Cole and Leukefeld summarize this struggle to design contextual interventions based on existent epidemiological data:

> Even if research findings indicate that social and contextual factors are critical to addressing HIV-risk behavior change for women, it is a challenging task to integrate these factors into practice. Current theories of HIV-behavior change should explore how these factors could be integrated into the theories and thus, integrated into interventions. (873)

Even though epidemiological research may identify social determinants of HIV transmission, public health practitioners do not agree on the best method for designing corresponding structural interventions.[35]

The second explanation for the lack of structural HIV interventions is that most public health researchers consider the modification of contextual forces beyond the scope of their interventions. Gupta et al. explain this widespread concern:

> Because many structural approaches address deeply entrenched social, economic, and political factors – such as gender or income inequality and social marginalization – that are difficult to change, they are commonly viewed as long-term initiatives that belong within the purview of broader economic and social

[35] Notably, public health practitioners also do not agree upon the best method to conduct individual-behavioral approaches. Although, as the first section of this text documented, many individual-behavioral interventionists have adopted rationality-based psychological theories to guide their health promotion strategies.

> development as measured through development achievements, such as the UN Millennium Development Goals (MDGs), rather than within the scope of HIV prevention. (764)

Since structural approaches are considered too broad for any one intervention to address, it seems that public health researchers do not even attempt to develop contextual interventions.

In an effort to address both concerns about contextual HIV prevention strategies, many public health practitioners have recently proposed what I term the *causal-pathway approach*. According to this model, structural interventions should target the specific pathways through which larger social forces promote HIV infection. Gupta et al. summarize this approach and its underlying assumptions:

> Total change of a distal structural factor might not be needed to exert its effect on HIV vulnerability… Some structural factors might be driving HIV risk or vulnerability proximally, while others may be distal, working through intermediate links or causal pathways. Taking a structural approach, therefore, begins by understanding the causal pathways in order to identify the points of maximum effect for any given intervention or agency. (767-8)

Gupta et al. suggest that although social forces may be the root cause of health inequalities, they promote risky behavior and, subsequently, HIV transmission through more direct pathways. Gupta et al. schematize this understanding using causal arrows that

emanate from an underlying structural force (e.g., gender inequality), proceed through specific pathways, and conclude at a particular risky practice (e.g., unprotected sex) (see Figure 2 in Gupta et al.'s "Structural Approaches to HIV Prevention"). According to this understanding, structural interventions do not necessarily need to transform social structures; instead, they can interrupt the processes by which social forces lead to HIV infection within certain populations.

There are two problems with the causal-pathway approach: the unidirectional understanding of causality and the centralization of power within social forces. First, the causal-pathway model assumes that larger social environments that are "distal" *cause* "proximal" risk factors embodied in individuals' behavior through a succession of intermediate, increasingly "proximal" modes (Gupta 765). Some public health researchers have critiqued this unidirectional causal understanding. Among the various critics, Krieger is one of the most influential. In "Proximal, Distal, and the Politics of Causation," Krieger argues that "contrary to the logic of the proximal-distal divide, within the very phenomena of disease occurrence and distribution… the distal and the proximal are conjoined" (224). Moreover, Krieger contends that the various components of most causal-pathways affect each other in non-linear and multi-directional ways: disease transmission is generated by "the intermingling of ecosystems, economics, politics, history, and specific exposures and processes at *every* level, macro to micro, from societal to inside the body" (227). I adopt this understanding of causality, where biological processes, behaviors, identities, and social systems are co-constitutive.

The second critique of the causal-pathway model, related to the first, focuses on the possession of power by social forces. Similarly to the epidemiological theories

reviewed in the first chapter, the causal-pathway approach depicts social forces as centralized and omnipotent structures that organize society. The causal-pathway model contends that all-powerful structural constructs (e.g., "gender inequality") define social institutions and relationships (e.g., "male physical and social dominance," "violence against women," "inability to negotiate condom use [because of] fear of violence") (Gupta et al. 768). This model repeats the common epidemiological understanding that power is centralized within social forces that then facilitate HIV/AIDS inequalities through various routes. In Chapter 1, I argued that this conception of social structure restricts intelligible structural interventions to abstract social change. Although the causal-pathway seems to identify tangible HIV prevention programs, its conception of power possessed by social forces inhibits our understanding of how causal-pathway interventions facilitate sustainable structural and behavioral change.

The causal-pathway model fails to conceptualize lasting structural and behavioral change because causal-pathway interventions do not alter the all-powerful root origin of health inequalities. Within the causal-pathway framework, structural interventions do not transform the underlying social forces that define the overall structure of society and the relationships within it. Even if an HIV prevention program transforms one part of a causal pathway, the modified sub-structure is constantly at risk of reversal given the omnipotence of the originary social force. For example, in Figure 2 of Gupta et al.'s causal-pathway from "gender inequality" to "unprotected sex," one structural intervention includes decreasing "male control over economic resources" (Gupta et al. 768). A tangible strategy toward this aim entails providing low-income African American women with the skills necessary for economic independence. However, according to the

model, “gender inequality” will continue to relentlessly promote men’s economic control over women. Within this framework, how can public health practitioners expect women to sustain economic independence? To be clear, I am not arguing that the structural interventions proposed by the causal-pathway model, such as creating organizations that teach groups of economically impoverished African American women the skills needed for economic independence, will fail to reduce HIV transmission. Rather, I contend that the causal-pathway approach lacks a *theoretical conception* of sustainable strategies for structural HIV prevention. Within the causal-pathway framework, we must still change the abstract, underlying structures to acquire lasting change.

If we want public health practitioners to invest in the development of structural interventions, we first need to develop a model of how structural interventions can facilitate sustainable changes to social structures and behavior. Currently, many researchers argue that “sustained progress in HIV prevention requires structural approaches rather than continuing to address individual-level factors” (Gupta et al. 773). However, it is doubtful that the public health field will shift toward structural interventions without a convincing theoretical model of their effectiveness. Thus, before we can expect public health practitioners to devote resources to the development of structural HIV prevention programs, we must first develop a model that describes how structural interventions can result in lasting change.

Foucault’s conception of power offers an understanding of how structural interventions can create sustainable structural change. As detailed in Chapter 1, Foucault contends that power structures are composed of a plurality of force relations that interact in complex systems (Foucault, *The History of Sexuality* 92). Importantly, power cannot

be possessed by centralized assemblies, such as “racism” or “sexism,” that organize social institutions or relationships. Instead, when relational forces overlap and reinforce each other they create only the *appearance* of an originary, underlying power source. Within this Foucauldian framework, structural interventions that change local force relations will realign the overarching pattern of power relations. For example, let us reconsider the structural HIV prevention program that creates an organization to provide a particular population of African American women with the skills necessary for economic independence. This intervention is perpetually at risk of failure given the omnipotence of the underlying “gender inequality” power force that the causal pathway model contends organizes society. By contrast, under Foucault’s model, the intervention’s effects (e.g., African American women’s economic independence) do not exist within a context of perpetual antagonism with an underlying social force. Instead, the intervention shifts the overlapping force relations (e.g., women’s marginalization) and, subsequently, rearranges the power system. Since Foucault’s model does not theorize an always-already existing antagonistic social force, HIV structural interventions can make a *sustainable* impact on the target community.

According to Foucault’s articulation of power, *individual* interventions can also generate sustainable change within communities by rearranging power systems. That is, if individual-behavioral interventions transform power relationships between individual people, they can also impact the overarching pattern of force relations within a particular power system. I am arguing that in addition to individual interventions, structural interventions that target larger social systems can also be effective. Moreover, it is possible that structural interventions will have a greater impact on realigning power

systems since they may affect a larger number of force relations within a local community.

In addition to imagining sustainable structural change, a useful conception of structural HIV prevention strategies must also specify exactly how structural transformation affects *behavioral* change. Mohanty's conception of identity production enables us to understand how structural interventions can impact sustainable changes in behavioral practices.[36] She suggests that identities are produced through local power structures. For example, she reviews one research project that documents how labor practices in Narsapur, India force many married lace-makers to adopt an exploitable identity (Mohanty 345). The local production system of Narsapur defines lace making as a "'leisure-time activity'" (Mohanty 345). As a result, the local power networks produce a "'non-working house[wife]'" identity that facilitates "the increasing pauperization of [lace-making] women, and keeps them totally atomized and disorganized as workers" (Mohanty 345). This example demonstrates how local power systems can exploit particular groups and generate identities that promote further marginalization. Similarly, we can hypothesize that within specific communities local power networks marginalize African American women and foster identities that place them at increased risk for HIV infection. By changing power systems, structural interventions can cultivate alternative identities that are not associated with high-risk behavior. For example, in certain contexts the institutionalized economic insecurity of many African American women leaves prostitution as one of the few options for employment. Thus, power systems within some

[36] Mohanty's theory of identity production is useful here, although it focuses on the impact of power systems on behavior and identity and obscures the reciprocal effect. Although the discussion below focuses on how identity and behavior are affected by power systems, note that the inverse also occurs. I focus on the impact of power systems on identity and behavior in order to highlight the potential benefits of structural interventions.

particular communities produce and maintain a “sex worker” identity for many low-income African American women. If structural interventions foster alternative employment opportunities, groups of low-income African American women will have other opportunities for economic survival besides prostitution. Through structural interventions, the target population can adopt alternative identities that promote safer behavior.

To address the structural causes that facilitate HIV transmission among African American women, public health researchers need to develop effective structural interventions. This chapter demonstrated how traditional conceptions of social structure fail to provide an understanding of how structural HIV prevention strategies can sustainably promote structures and behaviors that reduce HIV transmission. To motivate public health practitioners to invest in the development of structural interventions, we must theorize the lasting benefits of structural HIV prevention programs. Using Foucault’s conception of power and Mohanty’s formulation of identity production through local power systems, I proposed a new framework that envisions how structural interventions can create sustainable structural and behavioral change. Building on this framework, the next chapter explores how Foucault’s theories can steer the development of novel strategies to prevent HIV transmission among African American women.

Chapter 3:

A Systems Approach to Positive Deviance Research and Interventions

In the first two chapters, I explored conceptions of identity and power that provide useful frameworks for conducting localized epidemiological studies and structural interventions addressing the HIV/AIDS epidemic among African American women. Specifically, I demonstrated that Foucault's notions of power and Mohanty's conception of identity production offer useful perspectives for understanding HIV transmission and for building sustainable structural interventions. In this last chapter, I explore a specific strategy for innovative research and effective interventions that can reduce the HIV transmission rate among African American women. This strategy is called the PD approach. PD describes the situation within a community plagued by a particular disease wherein a subset of people always remains healthy (the "positive deviants"). PD research tries to identify the specific behaviors that protect positive deviants from disease acquisition. After conducting this preliminary research, public health practitioners then conduct PD interventions to spread these health-producing behaviors throughout the community. Interestingly, the vast majority of public health practice addressing the HIV/AIDS epidemic among African American women has not utilized the theory of PD. In the first section of this chapter, I argue that this failure to take up PD theory is a result of traditional models of sociocultural forces that render PD unintelligible. In the second section of this chapter, I invoke Foucault's conception of power systems to extend the traditional PD framework to the level of positive-deviant social systems.

A Theoretical Framework for Positive Deviance Research and Interventions Addressing the HIV/AIDS Epidemic among African American Women

Although traditional approaches to HIV prevention among African American women differ in their goals and methods, they share a top-down framework of public health practice.[37] The underlying approach to all of the main HIV prevention strategies includes four main steps: 1) identify specific factors contributing to HIV transmission; 2) develop theoretical solutions to address these factors; 3) implement an intervention based on the theoretical solutions; and 4) evaluate the intervention by measuring the change in HIV transmission and/or risky behaviors between the start of the intervention and its conclusion. What is most noteworthy about this general framework is that the strategies to prevent HIV transmission are developed by public health practitioners outside of the at-risk community. Of course, some researchers do conduct preliminary research on specific populations of at-risk African American women before designing interventions. However, the goal of this research is most often to either identify the specific, local factors that facilitate HIV transmission or to gain an understanding of the general "culture" within a local community so that the intervention can be tailored to the specific population. Despite this initial research, the researchers are still the ones who design the strategies to prevent HIV transmission that are then applied to specific communities.

According to some critics, this top-down model can never lead to sustainable change. In an interview with the business magazine *Fast Company*, public health practitioner Jerry Sternin states that "the traditional model for social and organizational change doesn't work… It never has. You can't bring permanent solutions in from

[37] See Chapter 2 for a description of the main HIV interventions specific for African American women.

outside" (Dorsey 1). These critics contend that top-down strategies rely on external resources (such as access to health supplies) and, subsequently, they are "difficult to sustain without ongoing external resources" (Marsh et al. 1177). The claim that sustainable change cannot be generated from outside a community or organization is probably too bold. In fact, there are many top-down public health projects that have cultivated lasting improvements in various communities (e.g., anti-smoking campaigns in the US). Moreover, some externally funded top-down interventions have been critical to cultivating widespread public health (the chlorination of drinking water in many countries is just one example). However, critics of the top-down public health model persuasively point to the difficulties of sustaining public health projects that rely mostly on external support.

The idea that top-down models of public health practice are difficult to sustain without significant external resources holds true for the traditional HIV prevention strategies that target at-risk African American women. For example, a common individual-biomedical approach seeks to treat STIs among African American women in order to reduce the rate of HIV transmission during sexual intercourse. When the research study concludes, the participants may no longer have access to this STI treatment. Similarly, at the end of an individual-behavioral intervention, the participants lose access to health supplies (e.g., condoms), motivational workshops, empowerment exercises, etc. Even many structural HIV prevention strategies require sustained external investment. For instance, the structural program outlined in "Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV" requires substantial external funding to provide free rental housing (Kidder at al.). Without

external support, traditional HIV interventions cannot be sustained within target communities.

Recognizing the limitations of top-down intervention models, some public health practitioners advocate for intervention strategies based on the theory of PD. PD refers to "the observation that in most settings a few at risk [sic] individuals follow uncommon, beneficial practices and consequently experience better outcomes than their neighbours who share similar risks" (Marsh et al. 1177). In its most basic form, the PD approach to public health practice has two components: 1) identify the uncommon yet health-producing (positive-deviant) behaviors practiced by some community members and 2) develop a strategy to encourage other community members to adopt the health-producing behaviors. This approach differs from the top-down model because it utilizes an effective strategy for maintaining health that is already practiced in the community. Thus, the researchers do not design and develop the solution to a given health problem; instead, they identify a health-producing strategy that currently exists within the community and then try to promote it. Furthermore, most PD strategies empower local communities to take ownership of the intervention. In fact, many researchers rely on community members to identify existing PD strategies and implement programs to encourage others to adopt the healthy behavior.

In many ways, the PD model can be understood as a feminist approach. Feminism has historical roots in valuing the experiences and knowledges of those who are traditionally viewed as disposable and incompetent. Indeed, the traditionally marginalized voices of diverse women (and some men) have, and continue to, enrich feminist perspectives. Similarly, the PD approach focuses attention on and learns from

the healthy behaviors that currently exist within communities. As I explore later in this chapter, the PD model also highlights the importance of community participation in PD research and interventions, thereby providing a voice to community members who are often excluded from conducting public health practice.[38]

Most PD interventions have focused on strategies to increase nutritional health within communities in developing countries (Marsh and Schroeder 3). This idea first emerged within the international health community in 1972 when Joe Wray published an editorial in *Tropical Pediatrics* titled "Can we learn from successful mothers?" (Berggren and Wray 7; Wray). Wray proposed that public health practitioners could learn successful feeding strategies from mothers whose children remain well nourished despite widespread community malnourishment. During the 1990s, the PD concept gained popularity and a handful of researchers utilized PD strategies to identify and spread behaviors that promoted healthy diets (Lapping et al. 129). Since then, some researchers have utilized PD inquiries to discover existent behaviors for improving maternal care of newborns, breastfeeding practices, and birth outcomes (Lapping et al. 130). More recent applications of the PD strategy include promoting successful and existent infection control measures within US hospitals (Aston) and developing healthy eating guides to reduce cancer risk in Guatemala (Vossenaar et al.).

The PD approach is a promising public health strategy because it can result in sustained change. The PD framework promotes health-producing behaviors that currently exist within a community and that do not rely so directly on external support.

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[38] Another research strategy, called the *community participatory research* approach, can also empower community members by involving them in the research process. Community participatory research differs from PD research in that it does not necessarily seek to discover existent protective behaviors within the community (although some community participatory research does).

Consequently, the promoted behavior will not depend exclusively on external resources and therefore can be maintained more effectively after the intervention ends. In addition, since positive-deviant behavior already exists within the community it is likely to be culturally acceptable. Public health practitioner David Marsh et al. summarize these unique advantages of PD approaches:

> Positive deviant behavior… is an uncommon practice that confers advantage to the people who practise it compared with the rest of the community. Such behaviours are likely to be affordable, acceptable, and sustainable because they are already practised by at risk [sic] people, they do not conflict with local culture, and they work. (1177)

Moreover, because community members lead the PD interventions, they can continue to spearhead the interventions even after the trained interventionists have finished their work. Indeed, many communities that have benefited from PD interventions use the same general approach for similar community-enriching endeavors, such as "cost sharing for local road construction or successfully demanding social services" (Marsh et al. 1178). The PD approach provides a sustainable alternative to traditional top-down models of public health interventions.

Despite the possibility of sustainable change inherent within the PD model, public health practitioners have not adopted this approach to address the HIV/AIDS epidemic among African American women. None of the review articles examined in the first two

chapters mention the theory of PD.[39] Moreover, the HIV prevention initiatives described in the public health literature do not employ strategies similar to those utilized in PD interventions. Instead, in most traditional HIV health promotion strategies, public health experts design strategies to reduce African American women's risk exposures associated with HIV transmission without considering current strategies that already exist in the community. For example, in "Efficacy of Computer Technology-Based HIV Prevention Interventions," Noar et al. describe HIV prevention strategies that utilize computer programs to disseminate information and provide interactive skills-building experiences to encourage safe sexual behaviors (107-8). Importantly, these computer-based technologies are not already-existing strategies that effectively promote healthy behaviors. Instead, they are designed by interventionists and brought into the community.[40]

Some may argue that the lack of PD approaches in HIV prevention strategies targeting African American women results from the logistical difficulty and limited scale-up potential of this type of intervention. PD approaches entail quite complex logistical issues for both public health practitioners and the communities of interest. Specifically, they require community mobilization by skilled neighborhood organizers, training of and dedication from intervention participants, the identification of rare "positive deviants," etc. Furthermore, since PD strategies originate from within a specific community, some public health practitioners question whether PD behaviors identified in one community can be applied to broader populations (Marsh et al. 1178). Despite these

[39] To my knowledge, only two research groups have adopted an explicit PD approach for researching HIV/AIDS prevention (discussed below). Neither group focuses on African American women.
[40] Noar et al. report that these computer-based interventions have shown some success in promoting safer sexual practices. To be clear, I am not questioning their efficacy but rather their sustainability.

potential disadvantages, previous research has found that PD approaches can lead to significant increases in community health (Marsh and Schroeder 3; Marsh et al. 1178; Aston 22).[41] Why, then, have interventions addressing the HIV/AIDS epidemic among African American women failed to incorporate the PD model?

The lack of PD approaches in HIV prevention among African American women can be at least partially explained by the popular underlying social epidemiological understandings of HIV transmission. As reviewed in Chapter 2, the contextual-behavioral framework is one of the most common understandings of African American women's disproportionate rate of HIV transmission. According to this framework, sociocultural forces facilitate behavior that places African American women at increased risk for HIV acquisition. I argued that the traditional contextual-behavioral framework assumes cultural and social forces as omnipotent constructs that organize society and largely dictate behavior. This totalizing, one-dimensional understanding of culture and social structure serves as a conceptual block to theorizing PD. If social and cultural forces pervade society and largely determine African American women's behavior, then the idea of PD becomes unintelligible. Within this traditional model, African American women who are not infected with HIV are imagined as the lucky survivors – the passive African American victims spared from the omnipotent cultural and social forces.

The traditional framework of HIV transmission among African American women through sociocultural forces also necessitates a top-down model of public health practice. If African American women are perceived as victims of dominant sociocultural forces,

[41] It is possible that some PD behaviors are effective largely because of their marginality. For example, some condom negotiation techniques may be successful because of their novelty. If these PD behaviors are promoted throughout a community, they may become less effective. The sustainable effectiveness of certain PD behaviors should be considered during PD research.

then there are two primary intervention strategies: 1) change the underlying sociocultural forces (racism, sexism, etc.) that facilitate HIV transmission or 2) empower individual African American women with knowledge, motivation, and skills so that they can resist the dangerous forces that place them at increased risk for HIV infection. Unfortunately, there are no theoretical strategies for public health practitioners to change the underlying structures of culture or society. Thus, researchers focus on empowering individual African American women so that they can avoid risky behavior. This is why the top-down model of HIV interventions seems necessary: It is the responsibility of public health practitioners to use their expertise and knowledge so that they can teach relatively "powerless" African American female victims how to counter the effects of disease-facilitating sociocultural forces. It is the underlying conception of culture and society as omnipotent monoliths that necessitates the top-down model of public health practice.

However, African American women have always been engaged in resistances within various US social systems. In her canonical *Black Feminist Thought*, Collins states that "one core theme [of Black feminist thought] concerns multifaceted legacies of struggle, especially in response to forms of violence that accompany intersecting oppressions" (26). African American women's resistance within diverse US social systems has ranged from activist work for African American women's suffrage (see Sojourner Truth's lectures "Woman's Rights" and "When Woman Gets Her Rights Man Will be Right") and investigative journalism about lynching in the southern US (see Ida Wells-Barnett's "Lynch Law in America") to the creation of "a powerful club movement and numerous community organizations" (Collins 26) during the 19th century. Another type of resistance is exemplified by the story of an enslaved woman named Celia who

was repeatedly raped by a Missouri plantation owner named Robert Newsome during the 19th century. After warning Newsome not to rape her anymore, Celia hid a stick in her cabin for protection. When Newsome entered Celia's cabin the following night and approached her, Celia used the stick to beat Newsome to death (McLaurin 30). Beyond these relatively well-known examples, African American women's resistance within US social systems is also expressed each day through various means. Collins argues that African American women's subjugated knowledge is a form of resistance: "For African-American women, the knowledge gained at intersecting oppressions of race, class and gender provides the stimulus for crafting and passing on the subjugated knowledge of Black women's critical social theory" (9). Many other expressions of daily resistance have been left out of our mainstream historical narratives. However, it is clear that African American women have a rich history of resistance within US social systems. It should be no surprise that African American women have also engaged in resistance with social systems that facilitate HIV transmission.

Foucault's articulation of power provides a useful framework for thinking about African American women's resistance and, specifically, PD. Foucault's formulation of power highlights how resistance resides with power systems. In fact, Foucault argues that resistance is always associated with power: "where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (Foucault, *The History of Sexuality* 95). For Foucault, resistance is not a reaction to a generalized power system. Instead, there is a "multiplicity of points of resistance" that "play[s] the role of adversary, target, support, or handle in power relations" (Foucault, *The History of Sexuality* 95). PD is one way these multiple points of

resistance manifest. Although power systems facilitate the transmission of disease within certain populations, there are always resistances within these power systems that decrease the risk of disease acquisition.

Foucault's notion of inherent resistances within force relations provides a rich framework for conducting both PD epidemiological research and interventions to address the growing rate of HIV transmission among African American women. If there are resistances with all power systems, there must be strategies of resistance within the force relations that facilitate the disparate rate of HIV infection among African American women. Foucault's conception of power and resistance encourages public health researchers to conduct localized studies that uncover how certain (groups of) positive-deviant African American women engage in resistance with force relations that contribute to HIV transmission. With this information, public health interventions can then spread the positive-deviant resistance strategies that are known to be effective and appropriate for particular communities.[42]

What would a PD intervention for the HIV/AIDS epidemic among African American women look like? We can look to the few existing PD strategies addressing sexual health for examples. One PD intervention was conducted in Vietnam in 2002 among female commercial sex workers (CSWs) and IDUs (Lapping et al. 132). This intervention involved a workshop where six CSWs and five IDUs collaboratively identified existent positive-deviant practices that prevented HIV transmission. For CSWs, the existent practices included specific ways to negotiate condom use (e.g., using phrases such as "[I'm] concerned about [your] family getting ill" during condom

[42] For a review of a potential method for promoting behaviors, see Lawrence Green et al.'s "Diffusion Theory and Knowledge Dissemination, Utilization, and Integration in Public Health."

negotiation) (Lapping et al. 132). For the IDUs, protective strategies included bending needles after injecting drugs so that the needles could not be re-used. For the subsequent intervention, the recruited CSWs and IDUs were trained as peer educators and conducted role-playing meetings to encourage other at-risk women to adopt the positive-deviant protective behaviors.

A PD strategy for African American women could mirror this general approach. Public health researchers could interview at-risk and HIV-negative African American women in specific communities to identify existent strategies that help prevent HIV transmission. For example, researchers could interview African American women who frequent "shooting galleries," where HIV transmission is thought to spread rapidly through needle sharing, in order to unearth how certain African American women protect themselves from contaminated needle usage.[43] Subsequent health promotion strategies could then train peer educators to devise strategies that encourage these practices.

Extending the Theory of Positive Deviance: Theorizing at the Level of Systems

Although traditional PD approaches focus on individual behavior, PD public health practice can benefit by also thinking at the level of systems. What is noteworthy about the traditional understanding of PD is that it is embodied in individuals' behaviors. For example, in the previous section I argued that public health practitioners could

[43] Public health practitioners in New York City have recently implemented this research model among a diverse group of IDUs uninfected with HIV or the hepatitis C virus (Friedman, "Positive Deviance Control-Case Life History"). The results of their investigative PD study offer strategies for promoting long-term avoidance of infections through injecting drug use (including strategies to reduce drug-withdrawal sickness that encourages immediate and often risky drug use).

identity the specific resistance strategies utilized by African American women that prevent HIV transmission and then spread these behaviors throughout the community. This individual-behavioral framework mirrors the common approach of most PD research. Speaking about PD in general, Marsh et al. state, “Positive deviance is a quick, low cost method to identify the strategies used by [positive deviant] people and encourage the rest of the community to adopt them” (1178). As noted by Marsh et al., traditional PD strategies focus on positive-deviant individuals and their behaviors. The goal is to “encourage” (Marsh et al. 1178) other community members to adopt the health-producing behaviors. This individual-behavioral approach has successfully improved health outcomes in many PD studies (Marsh and Schroeder 3; Marsh et al. 1178; Aston 22). However, an effective approach to PD may also identify and encourage positive-deviant social systems.

According to the traditional PD approach, analysis at the level of systems is unnecessary because all of the community members exist within the same social system. In fact, for some PD interventionists a unitary social system is a critical prerequisite for PD interventions (Dorsey 1). These public health practitioners argue that all of the target community members must have the same set of physical and social resources so that the intervention participants can adopt positive-deviant behaviors without external support and resources. According to these public health practitioners, there is no need to theorize beyond the individual because all of the intervention participants live in the same social system. However, the assumption that a specific community can have one social system and that everyone can share the same financial and social resources is misguided.

Foucault's understanding of power refutes the idea that everyone in a particular community exists within one social system. According to Foucault, power is exerted through various relational systems that are engaged in constant interaction. These constantly churning power systems create both local and broader webs of force relations that can be understood as "social structures." However, these "social structures" are not static societal frameworks: power does not create one blanket social structure in which everyone in a particular community lives. As Foucault states, power does not produce one unitary "system whose effects, through successive derivations, pervade the entire social body" (*The History of Sexuality* 92). Rather, power systems generate momentary social structures represented by patterns of continuously dynamic force relations.

Foucault's conception of power provides a model for thinking about PD at the level of systems. If within any given community there are multiple force relations that both reinforce and contradict each other, then we can view some force relations as facilitating and others as preventing the spread of disease. We should not only focus on identifying individual behaviors that protect from disease but also extend our focus to local social systems that facilitate health. [44] The PD interventions can then propagate not only healthy behaviors but also social systems that contribute to health maintenance. This understanding of positive-deviant systems is critical because "positive deviants" do not simply exist outside of power systems. Indeed, the "positive deviants" are linked within dynamic social systems that can enable or prevent the adoption of healthy behavior. If specific power systems facilitate healthy behavior, public health practitioners should promote these systems within the community.

[44] As noted in Chapter 2, this project focuses on how social systems impact behavior in order to extend the largely individual focus of many public health interventions. It is noteworthy that individual behavior also affects social systems in a co-constitutive manner.

The exact social systems that facilitate health cannot be known in advance. Nonetheless, there are many examples of where such configurations might be found. Social environments that empower African American women are likely candidates for indirectly promoting safe sexual and injecting drug use. For example, there is a long history of formal community organizations founded and organized by African American women (Hunter 67-8; 73; 97). PD research could focus on identifying these types of organizations that empower at-risk African American women through mutual support and leadership opportunities. Similarly, are there certain churches where at-risk African American women can thrive and find sanctuary in times of trouble?[45] Do after school programs offer similar forms of empowerment for younger African American women? Beyond these relatively formal systems, there may be informal social networks that promote health among at-risk African American women. Historians have documented informal community networks organized by African American women to support each other (Hunter 62). Similar networks may exist today, and certain mentoring relationships may encourage safe sexual and drug-related practices. PD research can identify these types of social systems that encourage protective behaviors and PD interventions can promote these social systems throughout specific communities.

However, one of the major obstacles to the PD approach is determining exactly *how* to encourage the adoption of behavior and/or the promotion of health-producing social systems. Foucault is helpful here in providing a theoretical framework for the most effective approach for promoting certain behaviors and/or power systems. In *Discipline*

[45] As mentioned above, in *Battered Love* Renita Weems explores how traditional gender roles and the exploitation of women can be perpetuated by some Christian thoughts. Nevertheless, many churches offer safe and empowering spaces for women.

and Punish, Foucault argues power is most effective when it is spread throughout social systems:

> … The productive increase of power can be assured only if, on the one hand, it can be exercised continuously in the foundations of society, in the subtlest possible way, and if, on the other hand, it functions outside… sudden, violent, discontinuous forms… (208)

Power is most effective when it is exerted continuously yet subtly throughout social systems.[46] This form of pervasive power can be found in individual force relations that spread throughout a social body. That is, within power systems there are various modes through which power can be exerted. The most effective form of power is generated when power transmits through multiple webs within a system, thereby creating an overarching pattern of force relations. Importantly, this notion of productive power relations contradicts traditional understandings where the level of power "possessed" by a certain source determines its effectiveness.

The idea that power works most effectively when spread through multiple force relations has important consequences for HIV intervention strategies targeting African American women. It suggests that the traditional public health intervention that attempts to change behavior by having public health experts transmit knowledge, motivation and skills to at-risk individuals is not the most effective strategy. Instead, effective behavior change strategies should fit in with the dispersed power systems that already operate

[46] Foucault's understanding of "the productive increase of power" (*Discipline and Punish* 208) draws on theories of self-regulation and surveillance. That is, he sees the spread of power as politically noxious. Here I am using a more positive sense of power.

within all communities. Thus, public health researchers should adopt community-based collaborative interventions that engage the entire community in identifying and cultivating existent social systems that facilitate protective behaviors. By having a large subset of the community involved, power can then be spread throughout the social system. In the context of the HIV/AIDS epidemic among African American women, this means that African American women should be actively involved with public health interventions addressing the spread of HIV within their communities.

The strategy of engaging a community to change behaviors and social systems has important ethical and political implications. Many scholars rightfully argue that the political implications of public health interventions should be considered through the lens of *biopower*. Sociologist Nikolas Rose states that such a perspective "brings into view a whole range of more or less rationalized attempts by different authorities to intervene upon vital characteristics of human existence – human beings, individually and collectively" (54). Public health practice is a form of biopower because it endeavors to improve health by changing behaviors, social structures, and subsequently people's very bodies. Rose describes the ethical implications of this type of work:

> This is an ethic in which the maximization of lifestyle, potential, health, and quality of life has become almost obligatory, and where negative judgments are directed toward those who will not, for whatever reason, adopt an active, informed, positive, and prudent relation to the future. (25)

The public health effort to modify social systems and behaviors within a community is undoubtedly a variation of what Rose calls "the government of *life*" (70). Although a comprehensive discussion of the ethical and political implications of public health interventions is beyond the scope of this chapter, it is important to engage the ethics of interventionists attempting to change behavior and/or social systems within specific populations.

There is a sense in most ethical critiques of public health work that public health practitioners are inappropriately intervening in communities to change behaviors. These critiques seem to imply that prior to the public health programs there were no forces intervening to modify behaviors. However, as Foucault reminds us, everybody exists within power systems at all times. Within every community there are always force relations facilitating certain behaviors. Public health interventions work with these existent power systems. That public health is immersed in power relations does not mean that it should be abandoned – public health initiatives are not unequivocally oppressive. Indeed, the nature of power is equivocal because power has a "productive role" (Foucault, *The History of Sexuality* 94). Power systems within local communities can facilitate behaviors that place members at increased risk for disease acquisition, or they can encourage protective behaviors. Or they can do both. Public health practice works within local power systems in order to realign force relations toward the generation of both risky and protective behaviors.

Of course, there is no magic bullet for public health crises, and "the government of *life*" (Rose 70) will generate its own norms that facilitate inequality and, subsequently, disease transmission. Nevertheless, public health history ranging from John Snow's

famous cholera investigation to the widespread iodization of salt reminds us that public health interventions can effectively work with power systems to produce lasting health improvements.

We must, though, keep in mind that there is a disturbing history of public health practitioners exploiting African American women in the name of public health.[47] A key question for all public health efforts is *who* gets to decide what behaviors and systems are promoted in the community and to whose benefit? Developing community-driven interventions may at least partially ensure that the interests of the community are prioritized, but it does not erase the ethical concerns. Even with community-driven interventions we should still critically consider who within the community is leading the project and to whose benefit. As public health practitioners, we should continue to grapple with the social and political implications of our work while recognizing that public health efforts are not inherently misguided.

Some traditional PD approaches to behavioral interventions have effectively utilized community-driven approaches. In fact, PD researcher Sternin emphasizes the need for community members to spearhead interventions. Sternin's approach to PD begins by establishing "a situation in which people – including those who need to change the way that they operate – can discover, on their own, a better way to do things" (Dorsey 2). After community members identify positive-deviant behaviors, the subsequent intervention also needs to emerge and operate from within the community. As Sternin instructs, "Don't teach new knowledge – encourage new behavior. Let the people who have discovered the deviations spread the word in their group" (Dorsey 3). One PD

[47] Refer to the introduction for a brief discussion of problematic public health initiatives targeting African American women.

intervention utilized a community-based approach to spread food preparation behaviors that increase the nutritional value of children's diet:

> In Vietnam… a health worker would invite 8 to 10 mothers into her home for medicinal-food training. As a price of entry, the mothers were required to bring a contribution of shrimp, crabs, and sweet-potato greens. The volunteers and the mothers would then use those ingredients, along with rice, to cook a meal for the entire group. After two weeks of this, the session was over. Most of the group would continue to gather shrimp and greens, and their children would continue to recover. Those mothers whose children didn't rehabilitate could re-enroll and go through the two-week process again, over and over, until their children were rehabilitated and the behavior became habitual. (Dorsey 3)

As this example demonstrates, PD interventions can mobilize entire communities to learn and adopt PD behaviors. Given the PD approach's potential for sustainable behavioral change, public health researchers addressing the HIV/AIDS epidemic among African American women should adopt this approach.

In addition to exploring community-driven behavioral PD interventions addressing the HIV/AIDS epidemic among African American women, we should also extend these epidemiological studies and interventions to the level of systems. Using similar techniques to those of the behavioral PD interventions, public health practitioners could develop PD interventions that empower the community to identify and promote positive-deviant systems. By "positive deviant systems," I refer to both structural systems

(e.g., existing and accessible sexual health, employment or housing services) and social systems (e.g., social support networks that thrive within particular communities) that enable specific populations of African American women to adopt safe sexual and injecting drug use practices. If intervention participants are empowered to identify these health-producing systems that already exist, they can then develop strategies to propagate these systems throughout the community. For example, imagine that a PD research project identified an empowering social support network among a small group of African American women that promotes safe sexual and drug injecting practices. Specifically, these at-risk African American women can rely on each other for emotional support, food, board etc. when necessary (e.g., when conflicts arise with their domestic partners). With this social and material support network, these African American women might feel empowered to negotiate condom use and other safe sexual practices. The PD intervention participants could then work to cultivate these types of social systems among other community members. This example shows how individuals and individual behaviors are intertwined with social systems. Through this type of community-driven work individuals can develop sustainable and empowering social networks that can indirectly prevent HIV acquisition.

The examples of behavioral and systems-level PD interventions provided in this chapter are entirely speculative. In fact, PD research must be conducted in order to unearth the protective behaviors and social networks that currently exist within specific communities of at-risk African American women. This chapter serves to encourage the adoption of PD research and interventions that may effectively reduce the HIV infection rate among African American women. By promoting power systems in specific

communities that facilitate the adoption of protective behaviors, PD approaches hold promise for not only stemming the HIV/AIDS epidemic among African American women, but also for rearranging the racist, sexist, and classist power systems that disadvantage African American women in other ways beyond HIV acquisition. Of course, PD interventions are not a comprehensive solution to the various racial, gendered and classed inequalities in the US, but they may contribute to fostering a more equitable social system.

Conclusion

As HIV/AIDS continues to disproportionately impact the lives of African American women, there is an increasingly urgent need to develop effective and sustainable interventions that can curb the epidemic. My research is based on the conviction that as we develop new health promotion strategies to address the HIV/AIDS epidemic among African American women, we should also analyze the underlying theories that have informed previous research and interventions. This analysis can reveal both the limitations and advantages of various theories and enable us to formulate more useful models of HIV transmission. With this tailored understanding, we can then develop more effective strategies for reducing African American women's high HIV transmission rates.

My research project documented how current understandings of African American women's disproportionate HIV infection rate conceptualize African American women as pawns of omnipotent social forces. This understanding ignores two important considerations for epidemiological research: 1) resistant force relations are always present within all power dynamics (Foucault's conception of power) and 2) identity is influenced by local power systems (Mohanty's articulation of identity production). Foucault's notions of power and Mohanty's concept of identity production refute the traditional understanding of social forces as vast complexes that organize society and direct behaviors. They highlight how multiple force relations create matrices of local power systems that can facilitate or curb disease transmission. This nuanced model of social forces provides a useful theoretical framework for the development of structural

interventions that can disrupt the social systems that facilitate HIV transmission among African American women. Moreover, guided by Foucault and Mohanty's theories of social forces, epidemiologists can focus on identifying power systems within local communities that facilitate the production of health-producing identities. Public health practitioners can then work with local communities to implement community-based strategies for spreading the existent social systems that promote protective behaviors. In this way, my project offers a fresh approach, drawing on existent strategies within communities, for more effective public health interventions to reduce the spread of HIV among African American women.

In this project, I have focused on broad understandings of identity and power. This is a useful starting place for developing more effective approaches to epidemiological research and interventions. Additional work should also utilize theories that foreground the experiences of African American women. It is important for public health practitioners to be informed by theories generated by and for African American women before designing epidemiological studies and interventions. Indeed, according to standpoint theory, African American women can have the clearest insight into power systems that affect their daily lives (see Chapter 11 in Patricia Hill Collins' *Black Feminist Thought*). Thus, the most effective public health strategies for reducing the disproportionate rate of HIV infection among African American women will likely draw on Black feminist theory as well as the perspectives of at-risk African American women within specific communities.

The arguments outlined in this project have focused on the research and interventions addressing the HIV/AIDS epidemic among African American women.

Although this epidemic has served as my case study, the concepts throughout this project can be applied, no doubt, to health disparity research in general. Since all health disparity research is influenced by underlying notions of identity and social forces, public health researchers working on various health disparity research projects could utilize the understandings of power systems and identity production outlined in this project. These frameworks could then inspire new epidemiological studies and interventions addressing various health disparities.

This project serves to inspire continuous reflexive analysis of how models of identity and social structure steer epidemiological research and interventions addressing health disparities. Of course, the final measure of the utility of these theories is their practical effectiveness. It is therefore through critical theoretical analysis informed by practical experience that we will pioneer the most effective strategies for reducing health disparities.

Works Cited

Adimora, A. A., V. J. Schoenbach, and I. A. Doherty. "HIV and African Americans in the Southern United States: Sexual Networks and Social Context." *Sex Transm Dis* 33.7 Suppl (2006): S39-45. Print.

Albarracin, D., J. C. Gillette, A. N. Earl, L. R. Glasman, M. R. Durantini, and M. H. Ho. "A Test of Major Assumptions About Behavior Change: A Comprehensive Look at the Effects of Passive and Active HIV-Prevention Interventions since the Beginning of the Epidemic." *Psychol Bull* 131.6 (2005): 856-97. Print.

Amaro, H. and A. N. Raj. "On the Margin: Power and Women's HIV Risk Reduction Strategies." *Sex Roles* 42.7-8 (2000):723-749. Print.

Aral, S. O., A. O'Leary, and C. Baker. "Sexually Transmitted Infections and HIV in the Southern United States: An Overview." *Sex Transm Dis* 33.7 Suppl (2006): S1-5. Print.

Aston, G. "Fresh Approaches Stem MRSA Tide." *Mater Manag Health Care* 18.8 (2009): 22-5. Print.

Barrow, R. Y., C. Berkel, L. C. Brooks, S. L. Groseclose, D. B. Johnson, and J. A. Valentine. "Traditional Sexually Transmitted Disease Prevention and Control Strategies: Tailoring for African American Communities." *Sex Transm Dis* 35.12 Suppl (2008): S30-9. Print.

Beck, Ulrich. *Risk Society: Towards a New Modernity*. London: Sage, 1992. Print.

Berggren, W. L. and J. D. Wray. "Positive Deviant Behavior and Nutrition Education." *Food Nutr Bull* 23.4 Suppl (2002): 9-10. Print.

Berman, S. M. and M. S. Cohen. "STD Treatment: How Can It Improve HIV Prevention in the South?" *Sex Transm Dis* 33.7 Suppl (2006): S50-7. Print.

Billingsley, A. and C. H. Caldwell. "The Church, the Family, and the School in the African American Community." *Journal of Negro Education* 60.3 (1991): 427-40. Print.

Broman, C. L., H. W. Neighbors, and J. S. Jackson. "Racial Group Identification among Black Adults." *Social Forces* 67.1 (1988): 146-58. Print.

Bunch, Charlotte. “Not by Degrees: Feminist Theory and Education.” *Learning Our Way: Essays in Feminist Education.* Eds. Charlotte Bunch and Sandra Pollack. Trumansburg, NY: The Crossing Press, 1983. 248-60. Print.

Bunton, Robin, Sarah Nettleton, and Roger Burrows, eds. *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. New York, NY: Routledge, 1995. Print.

CDC. “Estimates of New HIV Infections in the United States.” *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 3 Aug. 2008. Web. 3 Oct. 2009.

---. “First Report of AIDS.” *Morbidity and Mortality Weekly Report* 50.21 (2001): 429. Print.

---. “HIV/AIDS among African Americans” *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 15 Aug. 2009. Web. 3 Oct. 2009.

---. "HIV/AIDS among Women." *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 3 Aug. 2008. Web. 3 Oct. 2009.

---. "HIV/AIDS and African Americans" *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 28 June 2007. Web. 3 Oct. 2009.

---. "HIV/AIDS Basic Information." *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 3 Sept. 2008. Web. 3 Oct. 2009.

---. "HIV/AIDS Surveillance in Women." *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 5 May 2009. Web. 3 Oct. 2009.

---. "HIV/AIDS – United States, 1981-2000." *Morbidity and Mortality Weekly Report* 50.21 (2001): 430-4. Print.

---. "How Does HIV Cause AIDS?" *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 23 Jan. 2007. Web. 3 Oct. 2009.

---. "*MMWR* Analysis Provides New Details on HIV Incidence in U.S. Populations." *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 11 Sept. 2008. Web. 3 Oct. 2009.

---. *Mother-to-Child (Perinatal) HIV Transmission and Prevention*. Atlanta: Centers for Disease Control, 2007. Print.

---. “What is AIDS?” *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 20 Oct. 2006. Web. 3 Oct. 2009.

---. “Where did HIV Come from?” *Centers for Disease Control and Prevention Department of Health and Human Services.* USA.gov, 2 March 2009. Web. 3 Oct. 2009.

Coates, T. J. "Strategies for Modifying Sexual Behavior for Primary and Secondary Prevention of HIV Disease." *J Consult Clin Psychol* 58.1 (1990): 57-69. Print.

Collins, Patricia Hill. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge, 2000. Print.

Darbes, L., N. Crepaz, C. Lyles, G. Kennedy, and G. Rutherford. "The Efficacy of Behavioral Interventions in Reducing HIV Risk Behaviors and Incident Sexually Transmitted Diseases in Heterosexual African Americans." *AIDS* 22.10 (2008): 1177-94. Print.

Delange, G. G., P. H. Vaneede, J. H. Tenveen, H. W. Reesink, and P. N. Lelie. "Group-Specific Component and HIV-Infection." *Lancet* 2.8553 (1987): 282-3. Print.

Dorsey, David. “Positive Deviant.” *Fast Company: Learning* 19 Dec 2007. Web. 21 Sep 2009.

Eales, L. J., J. M. Parkin, S. M. Forster, K. E. Nye, J. N. Weber, J. R. W. Harris, and A. J. Pinching."Association of Different Allelic Forms of Group-Specific Component with Susceptibility to and Clinical Manifestation of Human Immunodeficiency Virus-Infection." *Lancet* 1.8540 (1987): 999-1002. Print.

Fausto-Sterling, A. "Refashioning Race: DNA and the Politics of Health Care." *differences* 15.5 (2004): 1-37. Print.

Friedman, S. R., P. Mateu-Gelabert, M. Sandoval, H. Hagan, and D. C. Des Jarlais. "Positive Deviance Control-Case Life History: A Method to Develop Grounded Hypotheses About Successful Long-Term Avoidance of Infection." *BMC Public Health* 8 (2008): 94. Print.

Friedman, S. R., H. L. Cooper, and A. H. Osborne. "Structural and Social Contexts of HIV Risk among African Americans." *Am J Public Health* 99.6 (2009): 1002-8. Print.

Foucault, Michel. *Discipline and Punish: The Birth of the Prison*. New York: Random House, Inc., 1995. Print.

---. *The History of Sexuality: An Introduction*. New York: Random House, Inc., 1990. Print.

Fox Keller, Evelyn. *The Century of the Gene*. Cambridge: Harvard University Press, 2000. Print.

Gao, F., E. Bailes, D. L. Robertson, Y. Chen, C. M. Rodenburg, S. F. Michael, L. B. Cummins, L. O. Arthur, M. Peeters, G. M. Shaw, P. M. Sharp, and B. H. Hahn. "Origin of HIV-1 in the Chimpanzee Pan Troglodytes Troglodytes." *Nature* 397.6718 (1999): 436-41. Print.

Gentry, Q., K. Elifson, and C. Sterk. "Aiming for More Relevant HIV Risk Reduction: A Black Feminist Perspective for Enhancing HIV Intervention for Low-Income African American Women." *AIDS Education and Prevention* 17.3 (2005): 238-52. Print.

Gilles, K., L. Louie, B. Newman, J. Crandall, and M. C. King. "Genetic Susceptibility to AIDS - Absence of an Association with Group-Specific Component (Gc)." *New England Journal of Medicine* 317.10 (1987): 630-31. Print.

Green, L. W., J. M. Ottoson, C. Garcia, and R. A. Hiatt."Diffusion Theory and Knowledge Dissemination, Utilization, and Integration in Public Health." *Annu Rev Public Health* 30 (2009): 151-74. Print.

Guinan, M. E. and L. Leviton. "Prevention of HIV Infection in Women: Overcoming Barriers." *J Am Med Womens Assoc* 50.3-4 (1995): 74-7. Print.

Gupta, G. R., J. O. Parkhurst, J. A. Ogden, P. Aggleton, and A. Mahal. "Structural Approaches to HIV Prevention." *Lancet* 372.9640 (2008): 764-75. Print.

Hader, S. L., D. K. Smith, J. S. Moore, and S. D. Holmberg. "HIV Infection in Women in the United States: Status at the Millennium." *JAMA* 285.9 (2001): 1186-92. Print.

Hammonds, Evelynn M. "Missing Persons: African American Women, AIDS, and the History of Disease." *Words of Fire: An Anthology of African-American Feminist Thought*. Ed. Beverly Guy-Sheftall. New York: The New Press, 1992. 434-49. Print.

---. "Seeing AIDS: Race, Gender, and Representation." *The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in the United States*. Eds. Nancy Goldstein and J. L. Manlowe. New York: New York University Press, 1997. 113-26. Print.

Hekman, Susan J., ed. *Feminist Interpretations of Michel Foucault.* University Park, Pennsylvania: The Pennsylvania State University Press, 1996. Print.

Hendrix, C. W., Y. J. Cao, and E. J. Fuchs. "Topical Microbicides to Prevent HIV: Clinical Drug Development Challenges." *Annual Review of Pharmacology and Toxicology* 49 (2009): 349-75. Print.

Hillier, S. L., T. Moench, R. Shattock, R. Black, P. Reichelderfer, and F. Veronese. "In Vitro and in Vivo: The Story of Nonoxynol 9." *J Acquir Immune Defic Syndr* 39.1 (2005): 1-8. Print.

Hird, Myra J. *Sex, Gender, and Science*. New York: Palgrace Macmillan, 2004. Print.

Hunter, Tera. *To 'Joy My Freedom: Southern Black Women's Lives and Labors after The Civil War*. Cambridge, Massachusetts: Harvard University Press, 1997. 187-218. Print.

Jaffe, L. R., M. Seehaus, C. Wagner, and B. J. Leadbeater. "Anal Intercourse and Knowledge of Acquired Immunodeficiency Syndrome among Minority-Group Female Adolescents." J Pediatr 112.6 (1988): 1005-7. Print.

Johnson, A. M. "Epidemiology of HIV Infection in Women." *Bailliere's Clinical Obstetrics and Gynaecology* 6.1 (1992): 13-31. Print.

Kidder, D. P., R. J. Wolitski, S. Royal, A. Aidala, C. Courtenay-Quirk, D. R. Holtgrave, D. Harre, E. Sumartojo, and R. Stall. "Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV: Rationale, Methods, and Implementation of the Housing and Health Study." *AIDS Behavior* 11.6 Suppl (2007): 149-61. Print.

Krieger, N. "Proximal, Distal, and the Politics of Causation: What's Level Got to Do with It?" *Am J Public Health* 98.2 (2008): 221-30. Print.

Lapping, K., D. R. Marsh, J. Rosenbaum, E. Swedberg, J. Sternin, M. Sternin, and D. G. Schroeder. "The Positive Deviance Approach: Challenges and Opportunities for the Future." *Food Nutr Bull* 23.4 Suppl (2002): 130-7. Print.

Lester, B. "The Social Context of HIV Transmission in the African-American Community." *Ethnicity & Disease* 3.4 (1993): 387-94. Print.

Lewis, D. K. and J. K. Watters. "Human Immunodeficiency Virus Seroprevalence in Female Intravenous Drug Users: The Puzzle of Black Women's Risk." *Social Science and Medicine* 29.9 (1989): 1071-76. Print.

Logan, T. K., J. Cole, and C. Leukefeld. "Women, Sex, and HIV: Social and Contextual Factors, Meta-Analysis of Published Interventions, and Implications for Practice and Research." *Psychol Bull* 128.6 (2002): 851-85. Print.

Lorde, Audre. “Age, Race, Class, and Sex: Women Redefining Difference.” *Words of Fire: An Anthology of African-American Feminist Thought*. Ed. Beverly Guy-Sheftall. New York, NY: The New Press, 1995. 284-291. Print.

Lyles, C. M., L. S. Kay, N. Crepaz, J. H. Herbst, W. F. Passin, A. S. Kim, S. M. Rama, S. Thadiparthi, J. B. DeLuca, and M. M. Mullins. "Best-Evidence Interventions: Findings from a Systematic Review of HIV Behavioral Interventions for US Populations at High Risk, 2000-2004." *Am J Public Health* 97.1 (2007): 133-43. Print.

Marsh, D., D. G. Schroeder, K. A. Dearden, J. Sternin, and M. Sternin. “The Power of Positive Deviance.” *BMJ* 329 (2004): 1177–9. Print.

Marsh, D. R. and D. G. Schroeder. "The Positive Deviance Approach to Improve Health Outcomes: Experience and Evidence from the Field. Introduction." *Food Nutr Bull* 23.4 Suppl (2002): 5-8. Print.

McLaren, Margaret. *Feminism, Foucault, and Embodied Subjectivity.* Albany, NY: State University of New York Press, 2002. Print.

McLaurin, Melton Alonza. *Celia, a Slave.* Athens: University of Georgia Press, 1991. Print.

Mize, S. J., B. E. Robinson, W. O. Bockting, and K. E. Scheltema. "Meta-Analysis of the Effectiveness of HIV Prevention Interventions for Women." *AIDS Care* 14.2 (2002): 163-80. Print.

Mofenson, L. M. "Technical Report: Perinatal Human Immunodeficiency Virus Testing and Prevention of Transmission. Committee on Pediatric AIDS." *Pediatrics* 106.6 (2000): E88. Print.

Mohanty, Chandra Talpade. "Under Western Eyes: Feminist Scholarship and Colonial Discourses." *Boundary 2* 12.3 (1984): 333-58. Print.

Neumann, M. S., W. D. Johnson, S. Semaan, S. A. Flores, G. Peersman, L. V. Hedges, and E. Sogolow. "Review and Meta-Analysis of HIV Prevention Intervention Research for Heterosexual Adult Populations in the United States." *J Acquir Immune Defic Syndr* 30 Suppl 1 (2002): S106-17. Print.

Noar, S. M., H. G. Black, and L. B. Pierce. "Efficacy of Computer Technology-Based HIV Prevention Interventions: A Meta-Analysis." *AIDS* 23.1 (2009): 107-15. Print.

Ordover, Nancy. *American Eugenics: Race, Queer Anatomy, and the Science of Nationalism*. Minneapolis: University of Minnesota Press, 2003. Print.

Pizzi, M. "Women, HIV Infection, and AIDS: Tapestries of Life, Death, and Empowerment." *Am J Occup Ther* 46.11 (1992): 1021-7. Print.

Roberts, Dorothy E. "Is Race-Based Medicine Good for Us?: African American Approaches to Race, Biomedicine, and Equality." *Journal of Law, Medicine, and Ethics* 36 (2008): 537-45. Print.

Rose, Nikolas. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press, 2007. Print.

Sanders Thompson, Vetta L. "The Complexity of African American Racial Identification." *Journal of Black Studies* 32.2 (2001): 155-65. Print.

Schilling, R. F., S. P. Schinke, S. E. Nichols, L. H. Zayas, S. O. Miller, M. A. Orlandi, and G. J. Botvin. "Developing Strategies for AIDS Prevention Research with Black and Hispanic Drug Users." *Public Health Rep* 104.1 (1989): 2-11. Print.

Semaan, S., L. Kay, D. Strouse, E. Sogolow, P. D. Mullen, M. S. Neumann, S. A. Flores, G. Peersman, W. D. Johnson, P. D. Lipman, A. Eke, and D. C. Des Jarlais. "A Profile of U.S.-Based Trials of Behavioral and Social Interventions for HIV Risk Reduction." *J Acquir Immune Defic Syndr* 30 Suppl 1 (2002): S30-50. Print.

Sherman, S. G., D. German, Y. Cheng, M. Marks, and M. Bailey-Kloche. "The Evaluation of the Jewel Project: An Innovative Economic Enhancement and HIV Prevention Intervention Study Targeting Drug Using Women Involved in Prostitution." *AIDS Care* 18.1 (2006): 1-11. Print.

Smoak, N. D., L. A. Scott-Sheldon, B. T. Johnson, and M. P. Carey. "Sexua Risk Reduction Interventions Do Not Inadvertendy Increase the Overall Frequency of Sexual Behavior: A Meta-Analysis of 174 Studies with 116,735 Participants." *JAIDS* 41.3 (2006): 374-384. Print.

Thomas, J. C. "From Slavery to Incarceration: Social Forces Affecting the Epidemiology of Sexually Transmitted Diseases in the Rural South." *Sex Transm Dis* 33.7 Suppl (2006): S6-10. Print.

Truth, Sojourner. "Woman's Rights." *Words of Fire: An Anthology of African-American Feminist Thought*. Ed. Beverly Guy- Sheftall. New York, NY: The New Press, 1995. 36. Print.

---. When Woman Gets Her Rights Man Will Be Right." *Words of Fire: An Anthology of African-American Feminist Thought*. Ed. Beverly Guy-Sheftall. New York, NY: The New Press, 1995. 37-8. Print.

Vitellone, Nicole. "The Syringe as a Prosthetic." *Body and Society* 9.3 (2003): 37-52. Print.

Vossenaar, M., E. Mayorga, M. J. Soto-Mendez, S. B. Medina-Monchez, R. Campos, A. S. Anderson, and N. W. Solomons. "The Positive Deviance Approach Can Be Used to Create Culturally Appropriate Eating Guides Compatible with Reduced Cancer Risk." *J Nutr* 139.4 (2009): 755-62. Print.

Wells-Barnett, Ida. "Lynch Law in America." *Words of Fire: An Anthology of African-American Feminist Thought*. Ed. Beverly Guy-Sheftall. New York, NY: The New Press, 1995. 36. Print.

Williams, P. B. "HIV/AIDS Case Profile of African Americans: Guidelines for Ethnic-Specific Health Promotion, Education, and Risk Reduction Activities for African Americans." *Fam Community Health* 26.4 (2003): 289-306. Print.

Wingood, G. M., and R. J. DiClemente. "Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women." *Health Educ Behav* 27.5 (2000): 539-65. Print.

---. "Cultural, Gender, and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents: Implications for the Development of Tailored Prevention Programs." *Ethn Dis* 2.4 (1992): 381-8. Print.

Wolfe, W. A. "Overlooked Role of African-American Males' Hypermasculinity in the Epidemic of Unintended Pregnancies and HIV/AIDS Cases with Young African-American Women." *J Natl Med Assoc* 95.9 (2003): 846-52. Print.

Wray, J. D. "Editorial: Can We Learn from Successful Mothers?" *J Trop Pediatr Environ Child Health* 18.4 (1972): 279. Print.

Zierler, S. and N. Krieger. "Reframing Women's Risk: Social Inequalities and HIV Infection." *Annu Rev Public Health* 18 (1997): 401-36. Print.

Primary Sources (Chapter 1)

Adimora, A. A., V. J. Schoenbach, and I. A. Doherty. "HIV and African Americans in the Southern United States: Sexual Networks and Social Context." *Sex Transm Dis* 33.7 Suppl (2006): S39-45. Print.

Amaro, H. and A. Raj. "On the Margin: Power and Women's HIV Risk Reduction Strategies." *Sex Roles* 42.7-8 (2000): 723-49. Print.

Aral, S. O., A. O'Leary, and C. Baker. "Sexually Transmitted Infections and HIV in the Southern United States: An Overview." *Sex Transm Dis* 33.7 Suppl (2006): S1-5. Print.

Barroso, J. and M. Sandelowski. "Substance Abuse in HIV-Positive Women." *J Assoc Nurses AIDS Care* 15.5 (2004): 48-59. Print.

Bogart, L. M., H. Cecil, and S. D. Pinkerton. "Intentions to Use the Female Condom among African American Adults." *J Appl Soc Psychol* 30.9 (2000): 1923-53. Print.

Coates, T. J. "Strategies for Modifying Sexual Behavior for Primary and Secondary Prevention of HIV Disease." *J Consult Clin Psychol* 58.1 (1990): 57-69. Print.

Coates, T. J. and M. D. Feldman. "An Overview of HIV Prevention in the United States." *J Acquir Immune Defic Syndr Hum Retrovirol* 14 Suppl 2 (1997): S13-6. Print.

Coates, T. J., R. D. Stall, J. A. Catania, and S. M. Kegeles. "Behavioral Factors in the Spread of HIV Infection." *AIDS* 2 Suppl 1 (1988): S239-46. Print.

Cohen, M. A. and C. A. Alfonso. "Dissemination of HIV: How Serious Is It for Women, Medically and Psychologically?" *Annals of the New York Academy of Sciences* 736 (1994): 114-21. Print.

Cohn, S. E. and R. A. Clark. "Sexually Transmitted Diseases, HIV, and AIDS in Women." *The Medical Clinics of North America* 87.5 (2003): 971-95. Print.

Craven, D. E., K. A. Steger, and C. Jarek. "Human Immunodeficiency Virus Infection in Pregnancy: Epidemiology and Prevention of Vertical Transmission." *Infection Control and Hospital Epidemiology* 15.1 (1994): 36-47. Print.

Delange, G. G., P. H. Vaneede, J. H. Tenveen, H. W. Reesink, and P. N. Lelie. "Group-Specific Component and HIV-Infection." *Lancet* 2.8553 (1987): 282-83. Print.

Des Jarlais, D. C. and S. R. Friedman. "HIV Infection among Intravenous Drug Users: Epidemiology and Risk Reduction." *AIDS* 1.2 (1987): 67-76. Print.

Duesberg, P. H. "AIDS Acquired by Drug Consumption and Other Noncontagious Risk Factors." *Pharmacol Ther* 55.3 (1992): 201-77. Print.

Eales, L. J., J. M. Parkin, S. M. Forster, K. E. Nye, J. N. Weber, J. R. W. Harris, and A. J. Pinching. "Association of Different Allelic Forms of Group-Specific Component with Susceptibility to and Clinical Manifestation of Human Immunodeficiency Virus-Infection." *Lancet* 1.8540 (1987): 999-1002. Print.

Felman, Y. M. "The Politics of Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus." *Seminars in Dermatology* 13.4 (1994): 286-90. Print.

Galvan, F. H., E. G. Bing, and R. N. Bluthenthal. "Accessing HIV Testing and Care." *J Acquir Immune Defic Syndr* 25 Suppl 2 (2000): S151-6. Print.

Gayle, H. D. and L. J. D'Angelo. "Epidemiology of Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection in Adolescents." *The Pediatric Infectious Disease Journal* 10.4 (1991): 322-8. Print.

Hader, S. L., D. K. Smith, J. S. Moore, and S. D. Holmberg. "HIV Infection in Women in the United States: Status at the Millennium." *JAMA* 285.9 (2001): 1186-92. Print.

Holland, J., C. Ramazanoglu, S. Scott, S. Sharpe, and R. Thomson. "Risk, Power and the Possibility of Pleasure: Young Women and Safer Sex." *AIDS Care* 4.3 (1992): 273-83. Print.

Horowitz, H. W., E. E. Telzak, K. A. Sepkowitz, and G. P. Wormser. "Human Immunodeficiency Virus Infection, Part I." *Disease-a-Month* 44.10 (1998): 545-606. Print.

---. "Human Immunodeficiency Virus Infection, Part II." *Disease-a-Month* 44.12 (1998): 677-716. Print.

Jaffe, H. W. "AIDS: Epidemiologic Features." *Journal of the American Academy of Dermatology* 22.6 Pt 2 (1990): 1167-71. Print.

Johnson, A. M. "Epidemiology of HIV Infection in Women." *Bailliere's Clinical Obstetrics and Gynaecology* 6.1 (1992): 13-31. Print.

Lanska, D. J. "Epidemiology of Human Immunodeficiency Virus Infection and Associated Neurologic Illness." *Semin Neurol* 19.2 (1999): 105-11. Print.

Lester, B. "The Social Context of HIV Transmission in the African-American Community." *Ethnicity & Disease* 3.4 (1993): 387-94. Print.

Levine, A. M. "Evaluation and Management of HIV-Infected Women." *Annals of Internal Medicine* 136.3 (2002): 228-42. Print.

Logan, T. K., J. Cole, and C. Leukefeld. "Women, Sex, and HIV: Social and Contextual Factors, Meta-Analysis of Published Interventions, and Implications for Practice and Research." *Psychol Bull* 128.6 (2002): 851-85. Print.

McClelland, G. M., L. A. Teplin, K. M. Abram, and N. Jacobs. "HIV and AIDS Risk Behaviors among Female Jail Detainees: Implications for Public Health Policy." *American Journal of Public Health* 92.5 (2002): 818-25. Print.

Mofenson, L. M. "Technical Report: Perinatal Human Immunodeficiency Virus Testing and Prevention of Transmission. Committee on Pediatric AIDS." *Pediatrics* 106.6 (2000): E88. Print.

Peruga, A. and D. D. Celentano. "Correlates of AIDS Knowledge in Samples of the General Population." *Social Science & Medicine* 36.4 (1993): 509-24. Print.

Pizzi, M. "Women, HIV Infection, and AIDS: Tapestries of Life, Death, and Empowerment." *Am J Occup Ther* 46.11 (1992): 1021-7. Print.

Porcher, F. K. "HIV-Infected Pregnant Women and Their Infants: Primary Health Care Implications." *Nurse Pract* 17.11 (1992): 1923-53. Print.

Potterat, J. J., D. D. Brewer, and S. Brody. "Blind Spots in the Epidemiology of HIV in Black Americans." *Int J STD AIDS* 19.1 (2008): 1-3. Print.

Schilling, R. F., S. P. Schinke, S. E. Nichols, L. H. Zayas, S. O. Miller, M. A. Orlandi, and G. J. Botvin. "Developing Strategies for AIDS Prevention Research with Black and Hispanic Drug Users." *Public Health Rep* 104.1 (1989): 2-11. Print.

Schuman, P. and J. D. Sobel. "Women and AIDS." *The Australian & New Zealand Journal of Obstetrics & Gynaecology* 33.4 (1993): 341-50. Print.

Sia, J., S. Paul, R. M. Martin, and H. Cross. "HIV Infection and Zidovudine Use in Childbearing Women." *Pediatrics* 114.6 (2004): E707-12. Print.

Sobo, E. J. "Inner-City Women and AIDS: The Psycho-Social Benefits of Unsafe Sex." *Culture, Medicine and Psychiatry* 17.4 (1993): 455-85. Print.

Sorvillo, F., L. Smith, P. Kerndt, and L. Ash. "Trichomonas Vaginalis, HIV, and African-Americans." *Emerging Infectious Diseases* 7.6 (2001): 927-32. Print.

Thomas, J. C. "From Slavery to Incarceration: Social Forces Affecting the Epidemiology of Sexually Transmitted Diseases in the Rural South." *Sex Transm Dis* 33.7 Suppl (2006): S6-10. Print.

Underwood, S. M., A. G. Buseh, M. K. Canales, B. Powe, B. Dockery, T. Kather, and N. Kent. "Nursing Contributions to the Elimination of Health Disparities among African-Americans: Review and Critique of a Decade of Research." *Journal of National Black Nurses' Association* 16.1 (2005): 31-47. Print.

Ward, J. W. and J. S. Duchin. "The Epidemiology of HIV and AIDS in the United States." *AIDS Clinical Review* (1997-8): 1-45. Print.

Wingood, G. M., and R. J. DiClemente. "Cultural, Gender, and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents: Implications for the Development of Tailored Prevention Programs." *Ethn Dis* 2.4 (1992): 381-8. Print.

---. "Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women." *Health Educ Behav* 27.5 (2000): 539-65. Print.

Withers, B. G., P. W. Kelley, J. G. McNeil, D. N. Cowan, and J. F. Brundage. "A Brief Review of the Epidemiology of HIV in the U.S. Army." *Mil Med* 157.2 (1992): 80-4. Print.

Wolfe, W. A. "Overlooked Role of African-American Males' Hypermasculinity in the Epidemic of Unintended Pregnancies and HIV/AIDS Cases with Young African-American Women." *J Natl Med Assoc* 95.9 (2003): 846-52. Print.

Wyatt, G. E. "Examining Ethnicity Versus Race in AIDS Related Sex Research." *Soc Sci Med* 33.1 (1991): 37-45. Print.

Zierler, S. and N. Krieger. "Reframing Women's Risk: Social Inequalities and HIV Infection." *Annu Rev Public Health* 18 (1997): 401-36. Print.

Primary Sources (Chapter 2)

Albarracin, D., J. C. Gillette, A. N. Earl, L. R. Glasman, M. R. Durantini, and M. H. Ho. "A Test of Major Assumptions About Behavior Change: A Comprehensive Look at the Effects of Passive and Active HIV-Prevention Interventions since the Beginning of the Epidemic." *Psychol Bull* 131.6 (2005): 856-97. Print.

Amaro, H and A. Raj. "On the Margin: Power and Women's HIV Risk Reduction Strategies." *Sex Roles* 42.7-8 (2000): 723-749. Print

Amaro, H., A. Raj, R. R. Vega, T. W. Mangione, and L. N. Perez. "Racial/Ethnic Disparities in the HIV and Substance Abuse Epidemics: Communities Responding to the Need." *Public Health Rep* 116.5 (2001): 434-48. Print.

Barrow, R. Y., C. Berkel, L. C. Brooks, S. L. Groseclose, D. B. Johnson, and J. A. Valentine. "Traditional Sexually Transmitted Disease Prevention and Control Strategies: Tailoring for African American Communities." *Sex Transm Dis* 35.12 Suppl (2008): S30-9. Print.

Berman, S. M. and M. S. Cohen. "STD Treatment: How Can it Improve HIV Prevention in the South?" *Sex Transm Dis* 33.7 Suppl (2006): S50-7. Print.

Blankenship, K. M., S. J. Bray, and M. H. Merson. "Structural Interventions in Public Health." *AIDS* 14 Suppl 1 (2000): S11-21. Print.

Coates, T. J. "Strategies for Modifying Sexual Behavior for Primary and Secondary Prevention of HIV Disease." *J Consult Clin Psychol* 58.1 (1990): 57-69. Print.

Coates, T. J. and M. D. Feldman. "An Overview of HIV Prevention in the United States." *J Acquir Immune Defic Syndr Hum Retrovirol* 14 Suppl 2 (1997): S13-6. Print.

Darbes, L., N. Crepaz, C. Lyles, G. Kennedy, and G. Rutherford. "The Efficacy of Behavioral Interventions in Reducing HIV Risk Behaviors and Incident Sexually Transmitted Diseases in Heterosexual African Americans." *AIDS* 22.10 (2008): 1177-94. Print.

Des Jarlais, D. C. and S. R. Friedman. "HIV Infection among Intravenous Drug Users: Epidemiology and Risk Reduction." *AIDS* 1.2 (1987): 67-76. Print.

Friedman, S. R., H. L. Cooper, and A. H. Osborne. "Structural and Social Contexts of HIV Risk among African Americans." *Am J Public Health* 99.6 (2009): 1002-8. Print.

Guinan, M. E. and L. Leviton. "Prevention of HIV Infection in Women: Overcoming Barriers." *J Am Med Womens Assoc* 50.3-4 (1995): 74-7. Print.

Gupta, G. R., J. O. Parkhurst, J. A. Ogden, P. Aggleton, and A. Mahal. "Structural Approaches to HIV Prevention." *Lancet* 372.9640 (2008): 764-75. Print.

Hendrix, C. W., Y. J. Cao, and E. J. Fuchs. "Topical Microbicides to Prevent HIV: Clinical Drug Development Challenges." *Annual Review of Pharmacology and Toxicology* 49 (2009): 349-75. Print.

Hillier, S. L., T. Moench, R. Shattock, R. Black, P. Reichelderfer, and F. Veronese. "In Vitro and in Vivo: The Story of Nonoxynol 9." *J Acquir Immune Defic Syndr* 39.1 (2005): 1-8. Print.

Inciardi, J. A., H. L. Surratt, S. S. Martin, D. J. O'Connell, A. D. Salandy, and R. A. Beard. "Developing a Multimedia HIV and Hepatitis Intervention for Drug-Involved Offenders Reentering the Community." *Prison Journal* 87.1 (2007):111-42. Print.

Kidder, D. P., R. J. Wolitski, S. Royal, A. Aidala, C. Courtenay-Quirk, D. R. Holtgrave, D. Harre, E. Sumartojo, and R. Stall. "Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV: Rationale, Methods, and Implementation of the Housing and Health Study." *AIDS Behavior* 11.6 Suppl (2007): 149-61. Print.

Logan, T. K., J. Cole, and C. Leukefeld. "Women, Sex, and HIV: Social and Contextual Factors, Meta-Analysis of Published Interventions, and Implications for Practice and Research." *Psychol Bull* 128.6 (2002): 851-85. Print.

Lyles, C. M., L. S. Kay, N. Crepaz, J. H. Herbst, W. F. Passin, A. S. Kim, S. M. Rama, S. Thadiparthi, J. B. DeLuca, and M. M. Mullins. "Best-Evidence Interventions: Findings from a Systematic Review of HIV Behavioral Interventions for US Populations at High Risk, 2000-2004." *Am J Public Health* 97.1 (2007): 133-43. Print.

Mize, S. J., B. E. Robinson, W. O. Bockting, and K. E. Scheltema. "Meta-Analysis of the Effectiveness of HIV Prevention Interventions for Women." *AIDS Care* 14.2 (2002): 163-80. Print.

Mofenson, L. M. "Technical Report: Perinatal Human Immunodeficiency Virus Testing and Prevention of Transmission. Committee on Pediatric AIDS." *Pediatrics* 106.6 (2000): E88. Print.

Neumann, M. S., W. D. Johnson, S. Semaan, S. A. Flores, G. Peersman, L. V. Hedges, and E. Sogolow. "Review and Meta-Analysis of HIV Prevention Intervention Research for Heterosexual Adult Populations in the United States." *J Acquir Immune Defic Syndr* 30 Suppl 1 (2002): S106-17. Print.

Newman, P. A., C. C. Williams, N. Massaquoi, M. Brown, and C. Logie. "HIV Prevention for Black Women: Structural Barriers and Opportunities." *J Health Care Poor Underserved* 19.3 (2008): 829-41. Print.

Noar, S. M., H. G. Black, and L. B. Pierce. "Efficacy of Computer Technology-Based HIV Prevention Interventions: A Meta-Analysis." *AIDS* 23.1 (2009): 107-15. Print.

Noguchi, K., D. Albarracin, M. R. Durantini, and L. R. Glasman. "Who Participates in Which Health Promotion Programs? A Meta-Analysis of Motivations Underlying Enrollment and Retention in HIV-Prevention Interventions." *Psychol Bull* 133.6 (2007): 955-75. Print.

Parrish, D. D. and C. K. Kent. "Access to Care Issues for African American Communities: Implications for STD Disparities." *Sex Transm Dis* 35.12 Suppl (2008): S19-22. Print.

Schilling, R. F., S. P. Schinke, S. E. Nichols, L. H. Zayas, S. O. Miller, M. A. Orlandi, and G. J. Botvin. "Developing Strategies for AIDS Prevention Research with Black and Hispanic Drug Users." *Public Health Rep* 104.1 (1989): 2-11. Print.

Scott, K. D., A. Gilliam, and K. Braxton. "Culturally Competent HIV Prevention Strategies for Women of Color in the United States." *Health Care Women Int* 26.1 (2005): 17-45. Print.

Semaan, S., L. Kay, D. Strouse, E. Sogolow, P. D. Mullen, M. S. Neumann, S. A. Flores, G. Peersman, W. D. Johnson, P. D. Lipman, A. Eke, and D. C. Des Jarlais. "A Profile of U.S.-Based Trials of Behavioral and Social Interventions for HIV Risk Reduction." *J Acquir Immune Defic Syndr* 30 Suppl 1 (2002): S30-50. Print.

Shepherd, J., G. Peersman, R. Weston, and I. Napuli. "Cervical Cancer and Sexual Lifestyle: A Systematic Review of Health Education Interventions Targeted at Women." *Health Educ Res* 15.6 (2000): 681-94. Print.

Sherman, S. G., D. German, Y. Cheng, M. Marks, and M. Bailey-Kloche. "The Evaluation of the Jewel Project: An Innovative Economic Enhancement and HIV Prevention Intervention Study Targeting Drug Using Women Involved in Prostitution." *AIDS Care* 18.1 (2006): 1-11. Print.

Smoak, N. D., L. A. Scott-Sheldon, B. T. Johnson, and M. P. Carey. "Sexual Risk Reduction Interventions Do Not Inadvertendy Increase the Overall Frequency of Sexual Behavior: A Meta-Analysis of 174 Studies with 116,735 Participants." *JAIDS* 41.3 (2006): 374-84. Print.

Ward, J. W. and J. S. Duchin. "The Epidemiology of HIV and AIDS in the United States." *AIDS Clin Rev* (1997): 1-45. Print.