What Condoms Can't Cover: Do structural factors predispose Black, African American, and Latina/o Adults in Harlem and the South Bronx to Engaging in HIV Sex Risk Behaviors?

Fabienne Snowden

Graduate Center, City University of New York

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What Condoms Can’t Cover: Do structural factors predispose Black, African American, and Latina/o Adults in Harlem and the South Bronx to Engaging in HIV Sex Risk Behaviors?

by

Fabienne Snowden

A dissertation submitted to the Graduate Center Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2015
This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Professor Willie Tolliver

________________________
Date

Chair of Examining Committee

Professor Harriet Goodman

________________________
Date

Executive Officer

Professor Harriet Goodman

Professor Bernadette Hadden

Professor Anthony Sainz
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK
Abstract

What Condoms Can’t Cover: Do structural factors predispose Black, African American, and Latina/o Adults in Harlem and the South Bronx to Engaging in HIV Sex Risk Behaviors?

By

Fabienne Snowden

Advisor: Dr. Bernadette Hadden

More than thirty years into the HIV/AIDS epidemic, Black, African American, and Latina/o communities continue to demonstrate the highest rates of HIV/AIDS in the US, accounting for 64% of all new infections and 58% of all AIDS diagnoses in 2009. Despite the longevity of this public health crisis, individually-based behavioral change approaches to HIV/AIDS prevention continue to be the most widely used and funded methods of combating HIV risk in Black, African American and Latina/o communities. These methods have been proven to lower the risk of HIV transmission, but HIV incidence in the US remains high at approximately 50,000 new infections each year. These stubbornly high new HIV infections reflect a limitation in individual and group-level HIV prevention interventions with regard to enduring behavior change.

This dissertation used secondary data analysis to investigate if the structural level factors of homelessness, incarceration, and poverty predisposed Blacks, African Americans, and Latinas/os to engaging in unprotected vaginal or anal sex. Baseline data collected for a NIDA-funded randomized controlled trial that tested the efficacy of a four-session, cognitive-behavioral skills-building HIV prevention intervention with HIV-seronegative non-injection drug users and their network members in Harlem and the South Bronx, was used to assess the relationship
between macro-level structural factors and micro-level individual sex risk behaviors. The baseline dataset consisted of a sample of 270 study participants between the ages of 18-59.

Sex-risk behavior was measured by the Vaginal Equivalent Episode (VEE), a weighted index of each episode of unprotected oral, vaginal and anal intercourse. Univariate analyses revealed that 74% of the study participants had a history of incarceration, 54% had been homeless in the past three months, and 74% were in receipt of public assistance. Chi-square values for bivariate analyses between the three structural-level variables and unprotected sex were all statistically significant. The final model in stepwise multiple regression illustrated that for every unit increase in income from selling sex, VEE scores increased ($\beta = .155$), and for every unit increase in incarceration, VEE scores increased ($\beta = .148$) as well. An increase in income from selling sex significantly predicted more episodes of unprotected anal, vaginal and oral sex ($p = .033$), and an increase in the number of times in jail, prison or a detention center significantly predicted more episodes of unprotected anal, vaginal and oral sex ($p = .012$). These research findings illustrate a direct relationship between macro-level structures and micro-level sex risk behaviors.
ACKNOWLEDGEMENTS

“We’re Not Alone”
Take a look in the mirror
And see the bigger picture
It’s good to be alive
It’s good to be alive
Nobody is a ‘island
We are part of an environment
The only way we’ gon’ survive
Is if we harmonize
(Nas, 2008)

The spell is cast.

A very special thanks is due to my mom – Mireille Snowden, Dr. Bernadette Hadden, Dr. Willie Tolliver, Dr. Anthony Sainz, Gene Adams, and all of the Black, African American, and Latina/o women who welcomed me into their lives and shared their experiences with me. Your unwavering support, wisdom, presence, patience, and love have grounded me in centering myself through the process of being with this work. In working on this dissertation, I have come to further embody what our ancestors dreamed of and died for.

My friends and family: you have sustained me, held me, listened to me, been in on-going conversations with me, and never let me forget who I am. When needed, ya’ll have taken the pieces of myself and returned them to me in their right order, reminding me of my song when the words were not clear. You are dear friends, precious family, divine gifts, and I cherish us being on this journey together. Light, love, and solidarity eternal.

This dissertation is the culmination of generations of hard work, life-times of love and support, years of research, and many conversations with people whom I adore. It is a milestone in my legacy of finding a way to create a way for the ones who are on their way. I give thanks. And one more shout out to my mom – everything I am, I’ve gotten from you, thank you.

The spell is done.
PREFACE

Definition of Terms

It is important to define several key terms that are used throughout this dissertation:
Black, African American, Latina/o, Hispanic, White/Euro-American, race, racism, ethnicity, men that have sex with men, people that are incarcerated, rate, incidence rate, prevalence rate, unemployment, communities living in poverty and strike.

Race refers to a group of people who are defined as being different from the elite and other minorities on the basis of perceived physical characteristics (Kinloch, 1974). Race is a social construct that has no genetic basis or biological basis. The consequences of such a social definition include awareness of subordinate group differences by the race group itself, and the utilization of these differences by the elite to rationalize institutionalized and individual level prejudice and discrimination (Kinloch, 1974). Racial groups such as Black, White, and American Indian are dynamic social constructs that are used to categorize groups of people (Omi & Winant, 1996).

Racism refers to the utilization and institutionalization of race as a defining construct in social interactions and institutional practices (Omi & Winant, 1996; Kinloch, 1974). Ethnicity, like race, is socially defined and has no biological basis. Ethnicity refers to a group of people who are defined by perceived cultural differences such as religion or nationality (Kinloch, 1974). Ethnicity and race can result in “rigid social differentiation, exploitation, and bitter conflict” within a racialized society (Kinloch, 1974 p. 53).

For this dissertation, Whites/Euro-Americans are conceptualized as people of European ancestry who were born and raised or migrated to the United States (US) who identify or are identified as White (Hughey, 2012). This term is also used to refer to people who do not have
European ancestry, but identify or are identified as White (Gualtieri, 2009). The purpose in using this term, White/Euro-American, in this dissertation is to be inclusive of White communities who identify or are identified as White who do not have or claim European ancestry. It is also used to be inclusive of communities of people who have or claim European ancestry, but do not self-identify as White or are not identified as White (Morrison & Chung, 2010; Gualtieri, 2009).

Black and African American refers to people with African ancestry who identify or are identified as being Black. Blacks and African Americans also refer to people who were born and raised in the US and can trace their heritage to those of African ancestry who migrated here from the Caribbean, South America, Africa and other parts of the African Diaspora (Gomez, 2004) or were forced to migrate to the US while enslaved (Byrd & Clayton, 1992). Through his timeless works, Cheik Anta Diop (1987) illustrates that the present day Blacks and African Americans are descendants of the aborigines of Africa as opposed to descendants of Arab or European peoples. The African Diaspora refers to the global dispersion of people who were formally concentrated on the continent of Africa (Brown-Manning, 2013; Palmer, 1998; Snowden, 1970). This dispersion occurred through the Atlantic Slave Trade of the 16th, 17th, 18th and 19th centuries, when over four million Africans were transported to the Americas and Caribbean Islands (Brown-Manning, 2013; Gomez, 2004). Africans on voluntary expeditions also migrated to these areas and other places throughout the world during these periods (Van Sertima, 2003).

Authors indicate that the term Hispanic underscores racial stereotypes by reinforcing social status and access or lack of access to resources (Garcia, 2012; Yankauer, 1987). The term Hispanic means to be from or trace one’s ancestry to Spain (Yankauer, 1987). Garcia (2012) further explains that Hispanic is a reference to Spain and has provided an increase in social
status, since, in the US, people from Spain are categorized as White and of European descent. Loveman and Muniz (2007) insightfully explain that Puerto Ricans were re-classified as White by the US census, and US officials through an expansion of the social definition of Whiteness. The expansion of this racial category was selectively applied to various Latina/o sub-groups, including groups of Cuban migrants (Galarraga, 2007).

Latina/o refers to the ethnicity of people who are members and descendants of the Hispanic Diaspora and people identifying as Black Latina/o, Indian Latina/o, or White Latina/o (Garcia, 2012). This term is used throughout this dissertation to refer to people of Latin or Spanish decent in place of the term Hispanic. Latina/o is a term that is utilized by people from Latin America (or Latina American ancestry) to assert their independence from Spain, and acknowledge their indigenous roots as a means of resistance to oppressive, race based structures (Garcia, 2012; Yankaour, 1987). Latina/o refers to both women and men, while deliberately privileging the former. The statistics used throughout this dissertation from the Kaiser Family Foundation and the Centers for Disease Control and Prevention (CDC) grouped people of Mexican, Puerto Rican and South American origin under the ethnicity of Hispanic or Latino. Data regarding the migrations and trajectory of health among Mexicans, Puerto Ricans and to a lesser degree, Cubans in the US were readily available and more widely documented than data regarding Latina/o nation-states in South America and the Dominican Republic (Galarraga, 2007; Hajat, Lucas, & Kingston, 2000).

The term communities of color is used throughout this dissertation to simultaneously identify Black, African American, and Latina/o communities in the US. This term is used to signify a commonality of experience within these communities with regard to the impact of structural factors on individual-level HIV infection risk behaviors.
Men that have sex with men is the preferred term of use in this dissertation as opposed to the term men who have sex with men (MSM). According to the CDC’s 2013 HIV Surveillance Report (2015), people whose transmission category is classified as male-to-male sexual contact includes men that have had any sexual contact with other men, and men that have had sexual contact with both men and women. In the CDC (2014d) surveillance systems, MSM indicates a behavior that transmits HIV infection. The use of ‘who’ in this term refers to identity despite the varying ways in which men that have sex with men self-identify with their sexual identity. The term and acronym, MSM is reductionistic and can have the unintended effect of depicting men that have sex with men as issues, rather than as human beings who engage in a set of behaviors (Khan & Khan, 2006). The use of MSM obscures social dimensions of sexual behaviors, conflates sexual identity and sexual behavior, and does not sufficiently describe the variations of sexual behavior (Young & Meyer, 2005). Repeated and overuse of these terms reifies a history of public health labeling of sexual minorities that supports heterosexist notions of what is and is not normal sexual behavior (Young & Meyer, 2005). A similar reasoning is reflected in the use of the term people that are incarcerated in place of the term inmates. The term inmates obscures the fact that the people that are incarcerated are human beings (Davis, 1999).

Rates refer to a measure of the frequency of an event compared with the number of persons at risk for the event. Rates are calculated by dividing the number of events (numerator) by the size of the population (denominator) and including a measure of time. When comparing rates between populations, it is typical to standardize the denominator in order to make direct comparisons. This standardization will depend on the magnitude of the local surveillance data—for national data, the population size is most often standardized to 100,000 (CDC, 2015).
*HIV incidence rate* is a measure of the frequency with which new cases of HIV infection occur, expressed explicitly per a time frame. Incidence rate is calculated as the number of new cases during a specified period divided either by the average population (usually mid-period) or by the cumulative person-time that the population was at risk.

*HIV prevalence rate* is the proportion of a population that is HIV infected at a specified point in time or during a specified period.

*Communities living in poverty* refers to communities where families with low income, identify as having limited means, but may not see themselves as being poor or without power (Burghardt, 2011; Berger, 2004)

The Bureau of Labor Statistics defines a person’s status as *unemployed* when she or he does not have a job, has been actively looking for work for the past four weeks and is currently available for work (BLS, 2009).

The use of the term "*strike*" as in "HIV/AIDS disproportionately strikes communities of color" for example, is used throughout this dissertation to describe the magnitude of disproportionate HIV/AIDS rates among communities of color. In this context, strike refers to having been hit or impeded by a disaster, disease or other unwelcome phenomenon that has harmful effects (Merriam-Webster, 2015). Disproportionate HIV and AIDS rates are a force that has hit communities of color living in or close to poverty in the US (Washington, 2006).
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CHAPTER I: GENERAL INTRODUCTION: PROBLEM FORMULATION AND STATEMENT OF THE RESEARCH

HIV/AIDS in the United States

Thirty years into the HIV/AIDS pandemic, the United States (US) has the highest prevalence for any country outside of the sub-Saharan region of Africa (Avert, 2014a; 2014b WHO, 2014). In 2013, 2.3 million people were living with HIV/AIDS throughout Europe and North America (AmFar, 2015). Almost half or 1.1 million people living with HIV/AIDS in these regions live in the US (Kaiser Family Foundation, 2014). Since the onset of this virus identification, more people have died of AIDS related causes in New York City than in Italy, the Netherlands, Spain and Switzerland combined (Hobbs, 2014). In addition, Black, African-American and Latina/o communities living in/close to poverty account for a majority of HIV/AIDS cases in the US (Denning & DiNenno, 2010). In 2012, Blacks, African-Americans and Latinas/os comprised 68% of all newly diagnosed HIV cases (CDC, 2014b).

The Prevalence of HIV and AIDS in Communities of Color

Currently, 510,000 of the 1.1million people living with HIV in the US are Black or African American and 220,000 are Latina/o (Kaiser Family Foundation, 2013b). Blacks and African Americans comprise only 12% of the US population (Kaiser Family Foundation, 2013a). However, they disproportionately accounted for 44% of all new HIV infections in 2010 (CDC, 2014a) and 44% of people living with HIV infection in 2009 (Kaiser Family Foundation, 2013a). In 2011, Blacks and African Americans accounted for 49% or almost half of all new AIDS diagnoses (Kaiser Family Foundation, 2013a). This is not a significant decline from Blacks and African Americans having represented 45% of all new HIV infections in 2006 and 49% of new AIDS diagnoses in 2007 (Kaiser Family Foundation, 2009).
Similarly, Latina/o communities continue to illustrate higher rates of both new HIV infections and people living with HIV than Whites/Euro-Americans (Kaiser Family Foundation, 2013b). Despite only representing 16% of the US population, Latinas/os accounted for 21% of all new AIDS diagnoses in 2011 and 21% of all new HIV infections in 2009 (Kaiser Family Foundation, 2013b). HIV/AIDS rates among Latina/o communities are lower than Blacks and African Americans. However, like their Black and African American counterparts, they continue to be disproportionately represented in overall HIV/AIDS rates in the US. Despite increased efforts of community education about methods of safer sex and increased funding for HIV testing, the rate of new HIV infections per year among Black, African American, and Latina/o communities has remained stable in recent years (CDC, 2011a; 2011b; Wheeler et al., 2010).

The number of new HIV infections among Blacks, African Americans and Latinas/os per year has declined from its peak in the mid to late 1980s. However, these rates still exceed the number of infections among Whites/Euro-Americans since that time. It is important to note that HIV/AIDS rates among Black and African American communities alone exceed the rate of HIV/AIDS infections among Whites/Euro Americans during their highest peak in the 1980s (Kaiser Family Foundation, 2013a). Alarmingly, Blacks and African Americans continue to account for a higher proportion of HIV infections at all stages of the disease – from new infections to HIV/AIDS-related deaths (Kaiser Family Foundation, 2013a; CDC, 2011a; 2011b). Latinas/os are not far behind, accounting for nearly 18% deaths among people with an HIV diagnosis in 2010 (Kaiser Family Foundation, 2013b). Between 2008 and 2010, the number of HIV related deaths among Latinas/os decreased by three percent (Kaiser Foundation, 2013a). During this period, HIV-related deaths among Blacks and African Americans decreased by 8% (Kaiser Foundation, 2013a).
Despite these significant successes, HIV-related deaths and HIV death rates continue to be the highest among Blacks and African Americans. In 2009, Blacks and African Americans accounted for more than half (56%) of all HIV-related deaths (Kaiser Family Foundation, 2013a). In addition, the survival time of Blacks and African Americans after an AIDS diagnosis continues to be lower than for all other races and ethnicities in the US (Kaiser Family Foundation, 2013a). These communities receive diagnoses at later stages of HIV infection due to a lack of access to health care. Consequentially, while the rates of HIV-related deaths decreased among Blacks, African Americans and Latinas/os between 2008 and 2010, the number of Blacks and African Americans living with an HIV diagnosis increased by 7% (Kaiser Family Foundation, 2013a).

In 2010, Black and African American men accounted for 70% of all new HIV infections among Blacks and African Americans (CDC, 2014). According to the CDC (2014), one in 16 Black and African American men will be diagnosed with HIV during their lifetime. HIV continues to be the fourth leading cause of death for Black and African American men between the ages of 25 and 44 (Kaiser Family Foundation, 2013a). In a study of 21 major US cities, 46% of Black, African American, and Latino gay and bisexual men were infected with HIV, in comparison to 16% of their White/Euro-American gay and bisexual male counterparts (Kaiser Family Foundation, 2013a). In 2010, male to male sexual contact accounted for 72% of all new HIV infections among Black and African American men and 51% of new HIV infections among Blacks and African Americans overall (Kaiser Family Foundation, 2013a).

Among Latinas/os, male to male sexual contact accounted for nearly 68% of new HIV infections among Latinas and 79% of new HIV infections among Latino men in 2010 (Kaiser Family Foundation, 2013b). Black, African American, and Latino newly infected men that have
sex with men are younger than their White/Euro-American counterparts. In 2010, Latino men between the ages of 13-24 that have sex with men comprised 28% of new HIV infections among Latino men that have sex with men (Kaiser Family Foundation, 2013b). This is almost double the rate of new HIV infection among White/Euro-American men of the same age group that have sex with men and whose rate of infection is 16% (Kaiser Family Foundation, 2013b).

In 2010, newly infected Black and African American men that have sex with men accounted for 45% of new HIV infections among Black men that have sex with men. Concomitantly, Black and African American men between the ages of 13-24 represented 55% of new HIV infections among all men that have sex with men in this age group. These rates are almost twice the rate of new HIV infections among Latinos and almost four times the rate of Whites/Euro-Americans of the same age groups that have sex with men (Kaiser Family Foundation, 2013a). New HIV infections occurred among Black, African American and Latino men between the ages of 13 and 24 that have sex with men at a rate that is higher than any other age or race of men having sex with men (Kaiser Family Foundation, 2009; 2013b).

In 2010, Latina women accounted for 15% of all new HIV infections in the US (Kaiser Family Foundation, 2013b). HIV incidence among Latina women is four times the rate of White/Euro-American women and one quarter of the HIV incidence rate among Black and African American women (Kaiser Family Foundation, 2013b). During 2010, Latinas represented 14% of new HIV infections among Latina/o communities (Kaiser Family Foundation, 2013b). This share is reflective of White/Euro-American women, but half of the share of Black and African American women (Kaiser Family Foundation, 2013b). In 2010, Black and African American women comprised 29% of all new HIV infections among Black and African American
communities, which was higher in proportion than Latina and White/Euro-American women combined (Kaiser Family Foundation, 2013b).

With an HIV incidence of 64%, Black and African American women accounted for the largest share of new HIV infections among all women in the US in 2010 (Kaiser Family Foundation, 2013a). HIV incidence among Black and African American women is 20 times the rate of HIV incidence among White/Euro-American women (Kaiser Family Foundation, 2013a). By the end of 2010, Black and African American women also accounted for 60% of the women living with an HIV diagnosis (Kaiser Family Foundation, 2013a). Recent data suggest that HIV incidence among Black and African American women from 2008-2010 has decreased by 21% (Kaiser Family Foundation, 2013a). However, researchers identify that when a disease within a population has maintained an excessively high-level over an extended period of time, it reaches its peak. This peak is then followed by a plateau where the disease either continues to maintain, decrease or increases in its rate.

According to the Kaiser Family Foundation (2013b), HIV transmission routes vary. HIV transmission patterns among Latina men vary from those of White/Euro-American men. Even though both groups are likely to have contracted HIV through male to male sexual intercourse, heterosexual transmission accounts for a larger share of new HIV infections among Latina men than their White/Euro-American male counterparts (Kaiser Family Foundation, 2013b). Similarly, Latina women are more likely to have contracted HIV through heterosexual transmission than White/Euro-American women (Kaiser Family Foundation, 2013). White/Euro-American women are more likely to contract HIV through injection drug use than Latina women (Kaiser Family Foundation, 2013b). Black and African American women are most likely to have contracted HIV through heterosexual transmission, which is also the most
common route of viral transmission for women in the US (Kaiser Family Foundation, 2013a).

**Disproportionality in Risk and Prevalence of HIV/AIDS: What is This Disease and Who is Contracting It?**

In July of 1981, the CDC published a Morbidity and Mortality Weekly Report (MMWR) documenting that during the previous two and a half years, 26 people had been diagnosed with a rare form of cancer called Kaposi’s sarcoma (KS) (CDC, 1981a). Twenty-five of the 26 people who had been diagnosed with KS were White/Euro-American and one person was Black or African American (CDC, 1981a). All of the people reported to have been diagnosed with KS were male and identified as homosexual (CDC, 1981a). A little over a month later, a MMWR published on August 28th illustrated that in addition to the 26 cases of KS, 15 cases of Pneumocystis carinii pneumonia (PCP) had been reported among homosexual men (MMWR, 1981b).

Since the publication of the July 1981 MMWR, 70 more cases of similar nature had been reported (CDC, 1981b). Not all of these mysterious cases of KS and PCP occurred in White/Euro-American homosexual men, although this is not highlighted in the opening of the report. Of these 70 cases, one case consisted of a woman and 23 were Black, African American or Latino men (CDC, 1981b). In addition, twelve cases were men who identified as heterosexual or whose sexual status was unknown (CDC, 1981b). The reports do not specify if the individuals that had been diagnosed with KS and/or PCP did or did not use injection drugs. On December 17th, 1982, a MMWR indicated that three of four infants had died of PCP. One infant remained in therapy for treatment for a severely low or impaired T-cell function (CDC, 1982). Three of the infants were Black, African American, Latino/a or Haitian. The parental health status was
known for two of the four infants and included intravenous drug use (CDC, 1982). These three MMWRs reiterate two key insights.

The first finding suggests that in its early stages, the virus and syndrome now known as HIV/AIDS was disproportionately prevalent among communities of men that engaged in sex with men, men that identified or were perceived as homosexual and White/Euro-American. This fact was widely publicized at that time, frequently to the detriment of these communities (Chirimuuta & Chirimuuta, 1987). The second finding that the MMWRs offered is that during its onset, gay or bisexual White/Euro-American middle and working-class communities were not the only communities where this virus was present. Other communities included heterosexuals, Blacks, African Americans, Latinos/as, women and people that use injection drugs. This was not as widely publicized as the former, although these communities were no less affected. However, in instances where this information was known, members of these communities were frequently referred to as not necessitating a preventative response (Osborn, 1986) or not being illustrative of a public health crisis that affected more than a negligible segment of the US population (Fumento, 1990). The focus was on White/Euro-American gay males.

By the end of the 1980s, research into HIV/AIDS in Black, African American and Latino/a communities had increased (Friedman, Sotheran, Abdul-Quader, Primm, Des Jarlais, Leinman, Mauge, Goldsmith, El-Sadr & Maslansky, 1987). In 1988, Selik and colleagues published a study that analyzed the variation in AIDS risk among Black, African American and Latino/a communities in the US. The findings of this study suggested that AIDS risk among Blacks, African Americans and Latino/as was almost three times that of White/Euro-American men (Selik et al., 1988). Similar trends of risk were present among women of color and White/Euro-American women (Selik et al., 1988). These findings were echoed in a study
published in 1996 that investigated the rates of tuberculosis, AIDS and mortality among people that use substances and receive public assistance in New York City (Friedman, Williams, Singh & Frieden, 1996).

The findings of this 1996 study suggested that people that use substances and receive public assistance are ten times more likely to contract AIDS, than people that do not use substances or are ineligible to receive public assistance (Friedman, Williams, Singh & Frieden, 1996). Although the study was published in 1996, data collection took place over an eight year period, beginning in 1984. The findings of these afore-mentioned research projects affirm the findings from a study of this time-period that explored the rates of sexually transmitted infections (STIs) among Black, African American and Latino/a communities. Moran, Aral, Jenkins, Peterman and Alexander (1991) found that syphilis and gonorrhea, like HIV/AIDS, are also disproportionately prevalent in communities of color. These authors reiterate a strong correlation between race, poverty and poor health (Moran et al., 1991). Wallace’s (1990) findings from his 1990 study add greater support to this observation.

**Focus on Individual Risk Factors in HIV/AIDS Prevention**

Individually-based behavioral change approaches to HIV/AIDS prevention continue to be the most widely used and funded methods of combating HIV risk in Black, African American and Latina/o communities (Medina, 2009; Sutton, Jones, Wolitski, Cleveland, Dean, & Fenton, 2009; Marin, 2003). Individually based methods of behavioral change in the context of HIV/AIDS prevention include promoting condom use, partner selection informed by HIV status, adherence to medication regiments, abstinence, avoidance of having concurrent sex partners and abstaining from sharing needles (Giami & Perrey, 2012).
These methods have been proven to lower the risk of HIV transmission, but HIV incidence in the US remains high. Authors have suggested that these stubbornly high new HIV infections reflect a limitation in individual and group-level HIV prevention interventions with regard to enduring behavior change. Consensus is growing that more attention should be paid to community-level interventions. Experts in social work and related fields agree that individually-based methods of HIV prevention do not take into account the historic and present castes of racism, prescribed gender roles and poverty (Wheeler, Hadden, Lewis, Van Sluytman & Parchment, 2010; Auerbach, 2009; Schuler & Mullings 2006).

A structurally based approach to HIV prevention would provide local, national, and federal resources aimed at changing the societal infrastructure within which individuals are yoked (Maturo, 2012). Macro-based methods for structural change include addressing the social and public health issues of homelessness, disproportionate incarceration rates, chronic joblessness, intergenerational poverty, and stigma – all of which are disproportionately present in communities of color living in poverty (Wheeler et al., 2010). Black, African American, and Latina/o communities living in poverty account for a majority of HIV/AIDS cases in the US (Denning & DiNenno, 2010). Addressing the structural drivers of this public health epidemic could better facilitate access to individual methods of prevention as a viable option (Auerbach, Parhurst & Caceres, 2011; Wheeler et al., 2010). Access to primary prevention and alternatives to criminalizing justice would clear the environmental constraints that are a barrier to condom use.

Structurally based approaches to HIV prevention in communities of color have been and continue to be suggested by experts in the field (Auerbach et al., 2011; Wheeler et al., 2010; Auerbach, 2009; Friedman, Cooper, & Osborne, 2009; Gupta, Parkhurst, Ogden, Aggleton, &
Mahal, 2008; Patterson, Heefe, 2008; Wallace, 1990; 1991a; 1991b; 1993; 1994; 2007; Wallace
& Wallace, 1990; 2000). However, the majority of HIV prevention programs both privately and
publicly funded, continue to target changing individual risky behaviors without addressing the
historic and present “high-risk social structure” (Roye & Snowden, 2013; Wheeler et al., 2010. p.
284). Hillard (1981) explains that a high-risk social structure is one where political forces enlist
public opinion to support social policies that transfer resources out of marginalized communities
for the benefit and maintenance of a status quo. Policy initiatives toward combating HIV
infection in communities of color continue to reflect this trend, despite the growing interest in
structural approaches to HIV prevention (Auerbach, 2009). Concomitantly, this public health
crisis continues to expand (Sutton et al., 2009).

**The Salience of Disproportionate Rates of HIV/AIDS in Black, African American and
Latina/o Communities in the US**

**Socio-Economic Constraints as Barriers to Care**

Numerous authors have identified how socioeconomic constraints directly and indirectly
negatively affect the health of people living with HIV/AIDS and at risk for HIV infection. Some
of the risk factors include higher levels of substance use, the exchange of sex to meet basic
needs, avoiding stigma, and lack of access to high quality health care (CDC, 2011a; 2011b;
Wheeler, 2006). Although Denning and DiNenno (2010) have identified poverty as a vector for
HIV infection, Sutton et al. (2009) and Moreno (2007) add that Black, African American and
Latina/o communities have higher levels of poverty, greater occurrences of institutionalized
racial discrimination, disrupted social networks caused by higher rates of incarceration, and
decreased access to preventative and needed health care. Wheeler and colleagues (2010) have
strongly advocated for the inclusion of the contexts within which Black, African American, and Latina/o sexual experiences occur in HIV prevention interventions.

Poverty, Blacks, African Americans, Latinas/os, and HIV/AIDS

Throughout history, socioeconomic status has been linked to the health of individuals, communities, and groups. People stratified in the lower end of the socio-economic hierarchy generally experience poorer health and higher rates of mortality than people who are located higher in this hierarchy (Adler et al., 1994). Reflecting this association, 75% of all HIV infections occur among people who are living at or under the poverty threshold (Denning & DiNenno, 2010). In the US, Blacks, African Americans, and Latinas/os comprise less than a third of the population (Kaiser Family Foundation, 2012a; US Census, 2012), however, 46% of Black African Americans, and 40% of Latinas/os live in poverty areas (Denning & DiNenno, 2010). These statistics reflect Washington’s (2006) observation that HIV and AIDS disproportionately strike the marginalized. Communities of color represent 28% of the US population (Kaiser Family Foundation, 2012a), however, Black, African American and Latina/o communities account for 64% of all people living with AIDS (Kaiser Family Foundation, 2012a; AIDS Institute, 2009). According to Denning and DiNenno (2010), poverty helps to account for some of the racial and ethnic disparities in HIV rates in the US. Unlike the national rates of HIV/AIDS, the rates of infection in communities living in poverty did not differ significantly between Blacks, African Americans, Latinas/os and their White/Euro-American counterparts (Denning & DiNenno, 2010). However, Black, African American and Latina/o families are almost five times more likely to live in poverty than Whites/Euro-Americans (Denning & DiNenno, 2010). Seventy-five percent of all HIV infections occur among people who are living at or under the poverty line (Denning & DiNenno, 2010). HIV rates in urban poverty areas in the
US mirror those in low-income countries such as Haiti and Ethiopia. As Mamadou Chinyelu (1999) has stated, the areas where low income Blacks, African Americans and Latinas/os are most likely to live still “ain’t nothing but...third world countrie[s]” (p. 10).

Experts have identified that access to health insurance improves access to care (Kaiser Family Foundation, 2009; 2013c). Recognizing that Blacks, African Americans and Latinas/os at risk for and living with HIV/AIDS may face greater barriers to accessing health care and treatment than their White/Euro-American counterparts is reiterative at best and an understatement at worst (Washington, 2006). Blacks, African Americans and Latinas/os are more likely to be employed in low-income and low wage work that offers very limited, if any, access to health care (Kaiser Family Foundation, 2013c). Communities of color comprise about four in ten or 39% of the non-elderly population of the US (Kaiser Family Foundation, 2013c), and Blacks, Africans Americans and Latinas/os constitute the largest share of this group (Kaiser Family Foundation, 2013c). This group has historically had less access to health insurance, and remains the group that is least likely to have insurance.

According to the Kaiser Family Foundation (2013c), nearly one in three Latinas/os is without health insurance. Latinas/os have the highest rate of being uninsured. Blacks and African Americans follow closely with one in five not having health insurance (Kaiser Family Foundation, 2013c). Whites/Euro-Americans have the lowest rates of being uninsured (Kaiser Family Foundation, 2013c). Medicaid coverage helps to remedy the disproportionate lack of access to health insurance experienced by communities of color living in or close to poverty. However, it does not fully offset the difference in coverage that leaves Blacks, African Americans and Latinas/os more likely to be uninsured (Kaiser Family Foundation, 2013c). The likelihood of being insured increases or decreases based on macro-level policy. Having
insurance increases an individual’s likelihood of receiving medical care, including HIV prevention and treatment. The passing of the Affordable Care Act has expanded health insurance coverage. However, it still falls short of providing adequate health care for all US citizens within its borders.

Denning and DiNenno’s (2010) findings affirm Washington’s (2006) assertion that the two populations with the highest HIV/AIDS prevalence in the US are people of color and people living in poverty – among which, Blacks, African Americans, and Latinas/os are disproportionately represented. Unemployment is one of several pathways into poverty (Wilson, 1997) and another area where communities of color are disproportionately represented. In the US, Blacks, African Americans and Latinos/as comprise almost 60% of people that are unemployed (Murphy, 2010). The rates of poverty reflect that Black, African American and Latina/o communities are among the majority of people who are incarcerated, homeless and illustrate disproportionate rates of HIV/AIDS infection.

**Homelessness, Blacks, African Americans, Latinas/os and HIV/AIDS**

Communities that are most susceptible to “pathogenic inequality” through lack of housing generally have insufficient access to resources that could carry them through periods of crises (Aidala & Sumartojo, 2007, p. S1). In the US, this includes the communities with the highest rates of HIV/AIDS, such as Blacks, African Americans, and Latinas/os. Reiterating the link with poverty, Blacks, African Americans, and Latinas/os are disproportionately represented among people experiencing homelessness. Together, these communities comprise 47% of people experiencing homelessness (SAMSHA, 2011), although, less than 30% of the US population (US Census, 2012). In 2010, Blacks and African Americans comprised 37% of people that were homeless, only five percent less than their White/Euro-American counterparts.
(SAMSHA, 2011), who constitute 78% of the US population (US Census, 2012). These statistics on homelessness are as alarming as they are outrageous. However, they are only a fraction of the racial and ethnic disparities among communities with the highest exposure to the US corrections system.

**Incarceration, Blacks, African Americans, Latinas/os, and HIV/AIDS**

Interlinked with poverty and homelessness (Reiman, 2007) is incarceration. The number of people incarcerated quadrupled between 1980 and 2008 (NAACP, 2013). Black, African American and Latina/o communities comprise less than one third of the US population but represented 58% of all people detained in 2008 (NAACP, 2013). Blacks and African Americans account for 1 million of the 2.3 million people incarcerated in the US (NAACP, 2013). Blacks and African Americans are incarcerated at six times the rate of Whites/Euro-Americans (Mauer & King, 2007). Latina/o communities follow closely with being incarcerated at double the rate of Whites/Euro-Americans (Mauer & King, 2007). Despite the US comprising only 5% of the world’s population, it has 25% of the world’s inmate population (NAACP, 2013). Although some studies point towards decreases in the inmate population (PEW, 2010), these trends are not as visible among Black, African American, and Latina/o communities (NAACP, 2013; Blakenship, Smoyer, Bray & Mattocks, 2005). Experts credit this extreme and racialized expansion of the punishment industry (Davis, 1999) to the privatization of prisons (Reiman, 2007) served by the policies of the War on Drugs (Alexander, 2010).

Drug-related incarceration is responsible for 50% to 80% of the growth of federal and state inmate populations, respectively since the 1980s (Blakenship et al., 2005). Drug offenses accounted for 26% of the total increase of White/Euro-American inmates in state programs. However, these same offenses led to a 42% increase in Black and African American inmates
Similarly, drug-related offenses have accounted for at least a 55% increase in female prison inmates (Blakenship et al., 2005). Black, African American and Latina women continue to be incarcerated more frequently than their White/Euro-American female counterparts (Blakenship et al., 2005). Authors have called attention to the findings that Whites/Euro-Americans use licit and illicit drugs at five times the rate of Blacks and African Americans. However, Blacks and African Americans are incarcerated at 10 times the rate of Whites/Euro-Americans (NAACP, 2013; Alexander, 2010; Blakenship et al., 2005). The US corrections system serves as a pathway for disproportionate exposure to HIV/AIDS in several ways. For example, prison personnel know sexual assaults and sexual intercourse among people that are incarcerated occur. However, condoms continue to be treated as illegal paraphernalia throughout most jails and prisons in the US (Sylla, Harawa & Reznick, 2010).

People that are incarcerated are not systematically tested for HIV infection. HIV tests are administered in one of three circumstances that include: inmate request, if the inmate is a member of a high risk group or reports as possibly having been exposed to the virus (AIDS.gov, 2012). Populations that are incarcerated in a jail or prison environment are exposed to more risk factors that are associated with HIV transmission, than people who are on probation or on parole (AIDS.gov, 2012). Since incarceration disrupts family and social networks, people that are incarcerated are vulnerable to exchanging favors for cigarettes, physical protection and/or money put into their commissary account (Blakenship et al., 2005). All of these factors render the person providing the favor with little room to negotiate the use of condoms, especially since inmates would likely be penalized for being in possession of these. The risks of contracting HIV from sharing needles, sexual assault or negotiating resources while incarcerated are exacerbated by HIV/AIDS being disproportionately present in the communities that are disproportionately
incarcerated (Blakenship et al., 2005). HIV transmission risk is also disproportionately present among communities of people that have a history of having been incarcerated although they may not be currently incarcerated. One out of seven people that are living with HIV pass through the correctional facility and most acquired the virus either before or after incarceration (AIDS.gov, 2012).

**Statement of the Research**

**Research Questions and Hypotheses**

The research question for this dissertation study is: *Do structural factors predispose Black, African American and Latina/o adults between the ages of 18 and 59 in Harlem and the South Bronx to engaging in sexually risky behaviors?* This research used secondary data analysis to investigate if structural level factors, such as homelessness, incarceration, and poverty predispose Black, African American, and Latina/o study participants to engaging in HIV sex risk behaviors, such as unprotected vaginal or anal sex. The disproportionate HIV rates among Black, African American, and Latina communities and the ongoing focus of HIV prevention being rooted in individual-level behavior change without addressing the macro level factors of homelessness, poverty or incarceration has raised several questions for this dissertation, which include specifically:

1. What are the sex risk behaviors of drug users and their sex/drug using networks in Harlem and the South Bronx?

2. Is a history of incarceration associated with higher episodes of unprotected vaginal and anal sex among the male and/or female study participants of the study sample?

3. Is poverty associated with higher episodes of unprotected vaginal and anal sex among the male and/or female study participants of the study sample?
4. Are past episodes of homelessness associated with higher episodes of unprotected vaginal and anal sex among the male and/or female study participants of the study sample?

5. What will cumulative oral, vaginal and anal unprotected sex risk scores, as measured by the Vaginal Equivalent Episode (VEE), a weighted sex risk index, look like among drug users and their sex/drug using networks?

6. What is the best model for predicting unprotected sex as measured by the Vaginal Episode Equivalent among drug users and their sex/drug using networks?

The hypotheses that were developed to address the above questions included the following:

Hypothesis #1: Study participants that have experienced past episodes of homelessness will have higher VEE scores (unprotected oral, vaginal and anal sex) than study participants that have not experienced past episodes of homelessness.

Hypothesis #2: Study participants that have a history of incarceration will have higher VEE scores than study participants that do not have a history of incarceration.

Hypothesis 3: Study participants that are living in poverty will have higher VEE scores than study participants that are not living in poverty.

Hypothesis #4: Poverty, incarceration and homelessness will be the best predictors of the criterion, unprotected sex, as measured by the Vaginal Equivalent Episode in a multiple regression model.
Definition of Study Variables

Unprotected sex is defined as vaginal and anal intercourse that is not protected by the use of the male or female condom (Hadden, 1998). The Vaginal Equivalent Episode (Desvarieux, Wittkowski, DeVincenzi, & Susser, 1996) assigned a weight of one-tenth of a point to unprotected oral sex, one point to vaginal sex and two points to anal sex. These scores were weighted to reflect their HIV transmission risk relative to one episode of vaginal sex. All the episodes of unprotected oral, vaginal and anal sex were added to compute the total VEE score. Poverty in the US is defined by the Census (2012) as the family's total income being less than the family's threshold. If the family’s regular expenditures are greater than what the family receives on a regular basis for work, then the US Census identifies this family, and every individual within it, as living in poverty (US Census, 2012). For the study, living in poverty includes receiving most monthly income from public assistance, public assistance for disability, family and friends, selling sex, theft, panhandling and or collecting cans. Homelessness is defined as not having a consistent, adequate, night-time residence or sleeping in a public or private place that is not designed to be regular sleeping quarters for human beings for seven consecutive nights (National Coalition for the Homeless, 2009c). Incarceration is defined as being confined in a prison, a jail or juvenile detention center (Bureau of Justice Statistics, 2015).

Purpose of Research

Experts in the field identify the ways in which structural factors are related to the micro-level phenomenon of people engaging in HIV risk behaviors as a means of resource negotiation and avoiding stigma (Auerbach et al., 2011; Wheeler et al., 2010; Wallace 2006; 1996; 1990a; 1990b; Wheeler, 2006). However, no studies to date, have specifically investigated if this relationship predisposes Black, African American and Latina/o adults between the ages of 18 and
59 in Harlem and the South Bronx to engaging in HIV sex-risk behaviors. It is essential to note that the use of the concept ‘predispose’ in this research question directly refers to the study hypothesis that the structural factors of homelessness, poverty and incarceration statistically increase the probability of Black, African American and Latina/o communities living in or close to poverty contracting HIV. I hypothesize that if Blacks, African Americans and Latinas/os were not disproportionately represented among the poor, homeless and incarcerated, they would not be disproportionately infected with HIV. Ongoing disproportionate HIV/AIDS prevalence in these communities necessitates examining if structural factors predispose these communities to engaging in HIV sex-risk behavior in two ways.

First, individual behavioral change models have not drastically reduced HIV/AIDS prevalence in communities of color (Wheeler et al., 2010; Fullilove, 2006; Smith et al., 2000). This informs health practitioners and policy makers that it is time to restructure the approach to HIV/AIDS prevention in communities with the highest rates of HIV infection. Second, there is a gap in research that specifically investigates if the relationship between structural-level factors and micro-level behaviors in the US is one where the former predisposes one to the latter. Adding to this body of research can become a means of further informing social work policy makers, researchers and practitioners as to whether or not a structural approach should and could be most effectively incorporated into HIV/AIDS prevention programs for communities with the highest rates of HIV infection.

**Definition of Structural Factors**

Structural factors are defined and described in a myriad ways throughout the literature. Most authors agree that structural factors are social, political and or economic policies that shape the options available in micro-level actions, thoughts and decision-making. Friedman, Cooper
and Osborne (2009) describe structural factors as social structures of a higher order and process, including, but not limited to racialized policing. These higher order structures and processes help to shape risk behaviors and networks. Similarly, Bowleg and Raj (2012) identify that structural factors include the social construction of poverty (Patteron & Keefe, 2008), the labor market outcome of unemployment (Wheeler et al., 2010) and the political-economic institution of incarceration (Alexander, 2010). The influence of these structural factors is magnified by the legacies of institutional race, gender and class-based oppression. According to Gupta and colleagues (2008), structural approaches include actions that can be implemented as either single policies or social programs. These efforts are aimed at changing the environments, conditions and/or contexts in which people live (Auerbach et al., 2011). This type of approach catalyzes social, economic and political change (Green & Rurak, 2011).

Gupta and colleagues (2008) add that structural approaches inherently and deliberately seek to address the factors that inform micro-level behavior in place of or in addition to addressing the behavior itself. The characteristic that defines structural approaches is their aim towards changing the economic, environmental, political or social factors that predispose specific communities to HIV risk and prevalence (Gupta et al., 2008). While some authors have described structural factors solely through the lens of social, economic and or environmental policy, others have added to these definitions by offering very clear maps of how these policies shape grassroots-level decision and sense-making in regard to HIV/AIDS risk and prevention.

Auerbach and colleagues (2011) explicate that structural approaches to HIV/AIDS prevention address core drivers of vulnerability to HIV. These central drivers of HIV prevalence inform the ability of individuals to protect both themselves and their sexual partners from the transmission of HIV. Wheeler and colleagues (2010) directly link social, economic and
environmental policies to individual behavior. According to their definition, macro-level factors are the structurally-informed context within which the individual is situated (Wheeler et al., 2010). Defining structural factors in this way illuminates the proximity between macro-level policies and micro-level options. In contrast, some authors see macro-level policies as being more distal from individual decision-making (Rotheram, Swendeman & Chovnick, 2009). Geronimus (2000) challenges this idea by identifying the historicity of structural factors as oppressive forces of social, economic and political stratification. Geronimus (2009) names structural factors as having been central in the production of the present inequalities and health needs experienced by Black, African American and Latina/o communities in the US.

**Linking Structural Factors and HIV Prevalence**

Various authors have linked structural factors with HIV prevalence in addition to describing and defining what these factors are. Rotheram and colleagues (2009) identify that most HIV prevention approaches are focused on the proximal causes of the transmission of the infection, such as sexual or at-risk behavior. Wheeler and colleagues (2010) elaborate that these proximal causes are inextricably informed by social constraints. Social constraints refer to the impeding of “an individual’s actions or thoughts that originate from the behaviors or expected behaviors of at least one other individual” (Wheeler et al., 2010 p. 275). Bowleg and Raj (2012) add that structural factors have been linked to increased vulnerability through a growing empirical base of research that has uncovered associations between these variables. Bowleg and Raj (2012) outline this evidence in their conversation about the increasing HIV prevalence among Black and African American men who identify as heterosexual. People of color are disproportionately affected by all of the identified structural factors including poverty,
homelessness, incarceration, unemployment, and historical and present institutionalized oppression.

**Poverty and HIV Prevalence**

Most authors that identify structural factors as increasing vulnerability to HIV risk and prevalence name poverty as one of these structurally-rooted influences. However, very few pieces of the literature name what is meant by this concept or how it is produced by structural forces as opposed to micro-level choices. A definition of poverty and how it constitutes as a construction of macro-level policies is central to the perspective of structurally-rooted drivers of HIV-risk. What constitutes as poverty and how this status is experienced relies heavily on the context within which it exists (Auerbach et al., 2011; Green & Rurak, 2011). In the US, poverty is defined by the US Census (2012) as the family's total income being less than the family's threshold. If the family’s regular expenditures are greater than what the family receives on a regular basis for work, then the US Census identifies this family, and every individual within it, as living in poverty (US Census, 2012).

Brady and colleagues (2009) and Abramovitz and Morgen (2006) identify that a nation’s poverty rate can either expand or contract according to the generosity of its welfare state. These authors explain that social welfare policies and taxation laws have the power to mitigate poverty in two ways. First, social welfare policies have the ability to buffer the risks inherent in a market-based economic system, including chronic unemployment and homelessness. Second, these tools can be used to organize the redistribution of economic resources in ways that enable individuals and communities to have their basic needs met (Brady et al., 2009; Abramovitz & Morgen, 2006). Since poverty and socioeconomic status are manipulated according to the
distribution of societal resources through social welfare policy and tax laws, economic wellbeing is a product of societal infrastructure more than of micro-level choices.

**Homelessness and HIV Prevalence**

Authors have long identified housing as a basic human right (Wolitski et al., 2007; Donohoe, 2004) and precursor to the maintenance of public health (Snowden, 2008). Accordingly, experts reiterate these assertions by advocating for housing to be a central component in approaches to HIV/AIDS prevention. Cisneros (2007) identifies that people that are experiencing homelessness or do not have consistent adequate night-time residence (National Coalition for the Homeless, 2009c) are more likely to contract HIV or to develop AIDS if already living with seropositive status. Cisneros (2007) explicates that this is due to the very hard life of living on the streets. People that are living without stable housing are up to six times more likely than housed people to become ill (National Coalition for the Homeless, 2009a). Since people that are seropositive have a compromised immune system and a lessened ability to fight off disease, their illness risk is even higher (National Coalition for the Homeless, 2009a). To add to the volatility of this condition, experiencing homelessness makes it extremely more difficult for people that are living with HIV/AIDS to obtain and maintain the necessary health care (Cisneros, 2007) and to keep a stable and low viral count (Wolitski et al., 2007).

People that sleep in a public or private place that is not designed to be regular sleeping quarters for human beings must cope with a multitude of potential detriments to their health and safety. Some of these challenges include communal sleeping arrangements, inadequate nutrition and constant movement; all of which can translate into barriers to maintaining stable sexual relationships (National Coalition for the Homeless, 2009a) and the slow healing of wounds (Cisneros, 2007). Homelessness imposes constraints on feasible options for well-being and the
meeting of basic needs. Women and men that are homeless may be forced to offer sex in exchange for the basic necessities of money, food or a warm place to sleep (Cisneros, 2007).

The barriers imposed by homelessness and poverty serve as drivers of HIV transmission and/or the development of AIDS. These barriers point to a strong relationship between HIV/AIDS and unstable living conditions. Cisneros (2007) adds the alarming fact that the life-span of a person that is homeless and seropositive is estimated in months, not years. The death-rate of people experiencing homelessness with seropositive status is five times that of a person of the same seropositive status that is living in stable housing (Cisneros, 2007).

Authors have also identified that lack of housing can influence self-medicating, drug use and risky drug use practices (Aidala & Sumartojo, 2007; Cisneros, 2007). People experiencing homelessness disproportionately experience substance abuse disorders which include injecting drugs and possibly sharing needles (The National Coalition for the Homeless, 2009a; Wolitski et al., 2007). Cisneros (2007) offers that people experiencing homeless or unstable living conditions were up to six times more likely to have recently used hard drugs, shared needles or exchanged sex for resources, than people who were not homeless. Aidala and Sumartojo (2007) add that a number of study findings illustrate that people who were formally homeless that obtain housing are more likely to cease, if not reduce sexual risk and drug-related behaviors. Similarly, people with stable housing are also more likely to have health care and less exposure to the environmental conditions that are conducive to HIV/AIDS prevalence (Cisneros, 2007).

Housing serves as a link to larger social processes that inform micro-level social and physical environments within which the day-to-day takes place (Aidala & Sumartojo, 2007). Expanded or contracted by social welfare policies and tax laws, housing can serve as a vector for disease or a vehicle for the maintenance of public health (Aidala & Sumartojo, 2007). Aidala
and Sumartojo (2007), state that pathogenic inequality inherent in macro-level social, political and economic structures is carried to susceptible communities through the pathway of housing.

**Incarceration and HIV Prevalence**

Authors explicate that incarceration in the US serves as a pathway for pathogen inequality in several key ways. For people that are incarcerated, the prison environment is a vector for high risk behaviors. Blakenship and colleagues (2005) identify that although sex and drug use generally decrease with incarceration, these behaviors take place in riskier ways inside of the prison, than outside. People that are incarcerated are more likely to share needles for drug use or for tattooing (Blakenship et al., 2005). In addition, condoms are not widely available to incarcerated communities. Lack of access to protection makes HIV transmission an added concern during sexual assaults behind prison walls (Blakenship et al., 2005). Authors have also identified that risk factors for HIV behind prison walls include untreated mental illness and living at or below the poverty line before and after incarceration (AIDS.gov, 2012; Reiman, 2007; Iguchi et al., 2005).

Iguchi and colleagues (2005) describe how the use of the US corrections system as a tool to control access to/use of illegal drugs has disproportionately diminished the health of Black, African American and Latina/o communities. Drug conviction can bar access to basic needs such as housing, health benefits in the form of food stamps, and employment with related health benefits (Iguchi et al., 2005). All of these factors contribute to the likelihood of an individual living in or close to poverty after having been released from incarceration (Reiman, 2007, Blakenship et al., 2005). Restricted access to basic needs constrains the micro-level options that people have access to and exposes them to greater risk for contracting HIV or developing AIDS, if already living with HIV. Alarming rates of exposure and prevalence to HIV through
incarceration is preventable. Experts have identified that if Black, African Americans and Latina/o communities were imprisoned in state or federally-operated correctional facilities at the same rate of White/Euro-American communities, imprisonment rates would decrease by 50% (NAACP, 2013).

The disproportionate presence of communities of color in institutions of poverty, incarceration and the outcome of homelessness blatantly illustrate the role of institutional oppression and racism at work (Solid-Ground, 2009). Institutional oppression is the systematic distribution of resources, power and opportunity to the benefits of a status quo and the exclusion of people who are being oppressed. In this context, the status quo is a largely White/Euro-American, middle class, heterosexual constituency, while the oppressed are overwhelmingly Black, African American, and Latino/a communities that are disproportionately living in poverty (Solid-Ground, 2009).

Age Groups and HIV Prevalence

In 2010, Castor, Pilowsky, Hadden, Fuller, Ompad, de Leon and colleagues (2010) published study findings from a randomized controlled trial that explored sexual risk reduction among HIV-negative non-injection drug users and their social networks. Pilowsky, Hadden and colleagues (2007) insightfully collected data on Blacks, African Americans, and Latinas/os who were between the ages of 18-59. The study differentiated between index participants and their social network members; with the screening requirement that index persons were between the ages of 18-30. Network partners had to be at least 18 years old, but no limit was placed on their age range, hence the broader age-range for the entire study sample. Eight years post the 2007 publication of their findings, people of color within these ages groups continue to be at
disproportionate risk for contracting HIV (Kaiser Family Foundation, 2014). The population for their study consisted of non-injection drug users who resided in Harlem and the South Bronx.

In 2010, Latino men accounted for 87% of all new HIV infections among Latinas/os in the United States. In this same year, Black and African American men comprised 70% of the new HIV infections among all adults and adolescent age Blacks and African Americans (CDC, 2014c). Blacks and African Americans accounted for 44% of all new HIV infections adults and adolescents aged 13 years and older (CDC, 2014a). In this same year, Black and African American youth comprising 7,000 or 57% of all new HIV infections among youth between the ages of 13-24 in the US (CDC, 2014b). Latina/o youth comprised 20% of new HIV infections in 2010 (CDC, 2014c). In 2011, 21% of the people diagnosed with HIV infections were between the ages of 13-24 (CDC, 2014a). Seventy-eight percent of these diagnoses were among people between the ages of 20-24. This is the highest number of HIV diagnoses of any age group in the US (CDC, 2014b). In 2012, African Americans comprised 47% of the estimated 47,989 diagnoses of HIV infection in the United States and accounted for the largest number of HIV diagnoses reported among young people between the ages of 13-24 (CDC, 2014). Sixty-seven percent of new HIV infections among Latino men that have sex with men occurred under the age of 35 (CDC, 2014c).

In 2010, more new HIV infections occurred among Black and African American men that have sex with men between the ages of 13-24 than any other subgroup of gay and bisexual men. HIV prevalence among young adult Black and African American men that have sex with men has increased from 48% to 69% of new HIV infections among young adults of this age group (CDC, 2011b). The CDC estimates that in 2010, 11,413 HIV diagnoses were among women between the ages of 13-14 (CDC, 2014b). Fifty-six percent of these infections were attributed to
heterosexual contact (CDC, 2014). Latinas accounted for 14% of the new HIV infections among all Latinas/os in the United States in 2010. The rate of new HIV infections among Black adolescents/adults was nearly eight times that of Whites/Euro-Americans and twice that of Latinas/os (Kaiser Family Foundation, 2014). The rate of HIV infection for Black men was the highest of any group and more than twice that of Latino (CDC, 2014a). Although the rate of infection between the age groups of 13-29 comprise the highest HIV prevalence for all of the age groups (CDC, 2011c), African Americans and Latinas/os, overall, are disproportionately affected by HIV/AIDS. Pilowsky and Hadden (2007) collected data on both the age groups that comprise the highest rates of HIV and the surrounding age groups that are also disproportionally represented among diagnosed infections.

**HIV in Harlem and the South Bronx**

HIV/AIDS is concentrated in New York City’s neighborhoods that have the highest rates of poverty and largest communities of color. Harlem and the South Bronx are among these neighborhoods (Iris House, 2011; NYC DOH, 2008). Harlem and the South Bronx are also among the neighborhoods that illustrate the highest rates of HIV infections in addition to the highest proportions of people living with HIV/AIDS in NYC (NYC DOH, 2008). In 2007, almost 6% of the people living with HIV/AIDS in Manhattan lived in Harlem (NYC DOH, 2008). Just under 10% of people living with HIV/AIDS in the Bronx lived in the South Bronx (NYC DOH, 2008).

**Rationale for Use of Secondary Data for this Dissertation**

**Micro-Level Rationale for Use of Secondary Data Analyses**

Secondary data analysis is the use and analysis of data that has been collected and gathered by another organization or researcher(s) for a project other than the one proposed
(Greenstein, 2006), but which can be analyzed for the exploration of related research interests without the huge resource costs that come with the conduct of original research. Using secondary data for the dissertation research satisfied multiple study purposes and research needs. First, using data that already existed saved time and resources. Pilowsky, Hadden and colleagues (2007; 2010) produced and developed a research project that collected data on macro-level factors and micro-level behaviors. To conduct a similar research project would require more time and a fiscal budget far beyond what was available for this dissertation project. Finally and perhaps most importantly, the data collected by Pilowsky, Hadden and colleagues (2007; 2010) contained the variables needed for the analyses of the dissertation research. These variables include whether the participants have a history of incarceration, have experienced episodes of homelessness and what their income was at the time of the study (Pilowsky et al., 2007).

**Macro-Level Rationale for Use of Secondary Data Analyses**

Researchers utilizing secondary data develop uses for already funded and completed research. Secondary data analysis honors the work of previous researchers by finding value in what has already been used for other purposes rather than the endless quest of collecting more data from research-exhausted participants who have already given so much of their time and from whom we have already accumulated massive amounts of data. In a seminal work, Robert B. Hill (1990) found that “Too many social work graduate students, both minority and white, are still being forced to incorporate experimental control groups in their masters or doctoral research even when such comparisons are not appropriate to achieving primary objectives of their studies” (p. 191). Hill (1980), like Linda T. Smith (1999) further cautions against research that requires that the researcher re-enter previously studied communities. Linda T. Smith (1999) and Patricia Hill Collins (2000) add that cultural generosity and political disempowerment have made
it possible for researchers to gain access to marginalized communities. Black, African American, and Latina/o communities living in or close to poverty continue to be marginalized by many of the structures that their cultural information has been used to inform (Kelley, 2008; Collins, 2000; Smith, 1999; Hill, 1990). Utilizing secondary data within the context of investigating a possible predisposing relationship between individual-level HIV sex risk behaviors among Blacks, African Americans and Latinos/os and macro-level structures inherently acknowledges the plethora of data that have already been collected about these communities.

Using secondary data analyses is a strategic use of the tools that have historically been used to subjugate the knowledge within marginalized communities, especially communities of color (Kelley, 2008; Collins, 2000; Smith, 1999). This dissertation research is a means of investigating how macro-level structures constrain micro-level options (Collins, 2000; Smith, 1999; Hillard, 1981). Hadden (2013) (personal communication, April 8th, 2013) and Robert B. Hill (1980) amplify this conversation in their analysis that by creating new, innovative and empirically sound ways to utilize previously collected data, social work researchers are on the cutting-edge of continuing to develop research-based practice, while conserving increasingly limited resources. Creating empirical approaches to work with constrained resources may be one of the few feasible ways to explore the possible relationship between macro-level structures and micro-level behaviors (Wallace, 1991). It is this very thinking that lead me to the use of Pilowsky’s and Hadden’s (2007) dataset in particular, rather than a macro-level dataset, to investigate if homelessness, incarceration and or poverty predispose Blacks, African Americans, and Latinoas/os to engaging in unprotected vaginal and or anal sex.
The Context within Which the Study Findings Will Be Reported

Conceptual Framework of the Dissertation Research Study

The conceptual framework of the dissertation research posits that macro-level factors of poverty, homelessness and incarceration disproportionately and negatively affect Black, African American and Latina/o communities (SAMSHA, 2011; Alexander, 2010; Denning & DiNenno, 2010), which in turn create conditions that predispose these communities to higher rates of HIV infection. The economic, political, social, environmental and historical constraints created by these macro-level factors create the conditions hypothesized by this author to predispose these communities to engaging in HIV/AIDS risk behaviors (Wheeler et al., 2010; Wheeler, 2006; Fullilove, 2006; Fullilove et al., 1990). Engaging in these at-risk exchanges, places Black, African American and Latina/o communities at increased HIV/AIDS risk (Jenness, Neaigus, Murrill, Wendel, Forgione & Hagan, 2011; Wheeler et al., 2010; Hadden, 1998).

This increased risk is reflected in these communities being in closest proximity to HIV/AIDS through having the highest overall number of HIV/AIDS infections, new infections per year and number of AIDS-related deaths (CDC, 2012; 2011a; Denning & DiNenno, 2010). Seropositive status is disproportionately present among people living at, or close to poverty (Denning & DiNenno, 2010), experiencing homelessness (National Alliance to End Homelessness, 2006) and/or incarceration (Rosen, Schoenbach, Wohl, White, Stewart & Golin, 2009).
Relationship of Proposed Research to Social Work Field

The Research Question as an Act of Resistance

The research question investigates the relationship between macro-level factors and micro-level HIV sex-risk behaviors in Black, African American and Latina/o communities. This proposed research is related to the social work field in numerous ways. Examining the relationship between macro-level institutions and micro-level actions encompasses ecological theory. Ecological theory posits that neither people nor the environment in which they are immersed can be understood without the context of their relationship to each other (Lee, 2001). Exploring the possible relationship between structural-factors and individual-level exchanges maintains the dual focus on the person-in-the-environment that social work posits. The structural focus of the research question counters what has continued to be an overwhelming reliance on individual and group-based approaches to HIV/AIDS research, prevention and thus, the social work profession (Wheeler et al., 2010).

Exploring the possibility of this relationship among Black, African American and Latina/o communities emulates the social work value of giving particular attention to the needs and means of re-empowerment of marginalized communities (Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2010) namely, communities of color (Pinderhughes, 1983). Black, African American, and Latina/o communities are disproportionately represented in incarceration, poverty and among communities with the highest rates of HIV/AIDS. This disproportionate representation illustrates the marginalized status and vulnerability of Black, African American, and Latina/o people, their families and their communities. In investigating the relationship between macro-level factors and micro-level behaviors, the research question counters pervasive “blame the victim” paradigms (Poindexter, 2010; Ryan, 1976, p. 3). Blaming the victim is
inherently maintained in individually-based approaches to HIV/AIDS prevention that do not also target macro-level factors (Wheeler et al., 2010). Investigating the possible direction of this relationship challenges the multiple systemic boundaries that have been constructed between individual-level outcome and societal-level policy (Lawson & Alameda-Lawson, 2001).
CHAPTER II: THE DIMENSIONS OF DISPORPORTIONATE RATES OF HIV/AIDS AMONG BLACK, AFRICAN AMERICAN, AND LATINA/O COMMUNITIES

Disproportionate rates of HIV/AIDS in Black, African American and Latina/o communities in the US have three salient dimensions. First, health deficits have been present among Black and African American communities since having been brought to and being enslaved in the US (Washington, 2006; Chinyelu, 1999; Semmes, 1996; Byrd & Clayton, 1992). Health deficits among Mexican and Puerto Rican Latina/o communities have been present since immigrating to and acculturation in or having been annexed by the US (Galarraga, 2007; Lara, Camboa, Kahramanian, Morales & Bautista, 2005; Molina, 2006; Hajat, Lucas & Kington, 2000). These health disparities are amplified by social, political, and economic inequality (Lara et al., 2005; Wallace, 1991). Health deficits among these communities are the product of oppression and have yet to be ameliorated (Molina, 2011; Semmes, 1996). Second, these health deficits are used to maintain a political economy of oppression. The deteriorating health among Black, African American, and Latina/o communities serves as a consumer base for the medical profession and is used to illustrate the false construct of biological supremacy of White/Euro-Americans (Schultz & Mullings, 2006; Washington, 2006; Semmes, 1996).

The third dimension of this social and public health problem is the use of disproportionate HIV/AIDS rates to maintain numerous economies, including an economy of oppression, and increase national communicability of viral transmission (Wallace, 1991). Wallace (1991) identifies that viruses and bacteria do not adhere to geological, racial, gender or class boundaries. The maintenance of these economies continues to be generated at the immediate expense of Black, African American, and Latina/o families. In the US, marginalized communities have historically been and continue to be disproportionately Black, African
American (DuBois, 2007), Latina/o (Hajat et al., 2000) and low-income (Denning & DiNeno, 2010, Reiman, 2007). Simultaneously, these communities have continued to experience an overall decline in health since having been exposed to living and working in the US (Galarraga, 2007; Byrd & Clayton, 1992), and specifically for Blacks and African Americans, enslavement in the US (Semmes, 1996).

The Trajectory of Black, African American, and Latina/o Health Deficits as a Product of Oppression

Epidemic rates of HIV/AIDS in Black, African American and Latina/o communities are an indicator of declining health among people of color in the US (Jackson & Cummings, 2011; Molina, 2011; Lara et al., 2005; Hajat et al., 2000; Semmes, 1996; Byrd & Clayton, 1992). Hajat and colleagues (2000) and Galarraga (2007) illustrated that Latina/o sub-groups such as Mexicans, Puerto Ricans, South Americans and Cubans each have their own history of migration to and experiences in the US. Prior to 1848, most of the southwest region of the US was part of Mexico (Molina, 2011; Hajat et al., 2000). The Treaty of Guadalupe-Hildago permitted the US to annex 55% of Mexico’s land and the people within this territory (US National Archives & Records Administration, 2014). Therefore, since the US expanded into their territory, the concept of immigration is not applicable for many Mexican Americans and their descendants (Galarraga, 2007; Hajat et al., 2000). In addition to Mexican communities already living on what had become US territory, Mexicans immigrated to the US as early at 1882 to fill the labor demand created by the Chinese Exclusion Act (Molina, 2011; Rodriguez, 2000). In 1910, Mexican emigration continued as a means of escaping political unrest and/or supplementing economic scarcity amplified by the Mexican Revolution (Molina, 2011; Hajat et al., 2000).
From the time of the annexation of Mexico’s territory until the 1930s, Mexicans were recorded by the US Census as White or of European descent (Rodriguez, 2000).

Despite the “whitening” of this indigenous Latina/o community, Mexicans annexed to and living in the US were treated as social outcasts, federal expenditures and carriers of disease (Loveman & Muniz 2007, p 915; Molina, 2006; 2011; Rodriguez, 2000). Fifty years after the Mexican American war, the US annexed Puerto Rico as a result of the Spanish American War of 1898 (Hajat et al., 2000). In 1899, 62% of Puerto Rico was identified by the US Census as White or of European descent (Loveman & Muniz, 2007). Seven years later, Puerto Ricans were written into law as being US citizens with very limited benefits accrued to them by this arrangement (Hajat et al., 2000). In less than 10 years, this commonwealth territory/colony became the location of population control projects that sterilized one third of Puerto Rican women on the island (Guidotti-Hernandez, 2010). Mexicans and Puerto Ricans were exposed to hazardous working conditions during long hours in harsh climate and industrial conditions, unsanitary housing, constrained opportunity for advancement in the US and infrequent wage payments (Molina, 2006; 2011; Galarraga, 2007).

Mexicans and Puerto Ricans were simultaneously welcomed by US industries as expendable labor and blamed for problems created by structural factors that were far beyond the control of the workers (Molina, 2006; 2011; Chinyelu, 1999). Both groups experienced adverse health effects in relation to acculturation (Lara et al., 2005), living in or below poverty and the stress of on-going race and culture-based oppression (Molina, 2011; Galarraga, 2007; Schildkraut, 2005; Hajat et al., 2000). Mexicans living in and immigrating to the US that were suspected of having a disease or being feebleminded were deported to Mexico, regardless of having American citizenship (Molina, 2011). Latinas/os served as the “experimental material”
(Byrd & Clayton, 1992, p. 194) for pseudo-scientific experiments that left some research participants sterile and others dead (Guidotti-Hernandez, 2010; Molina, 2006). Whiteness, for these Latina/o communities did not necessarily entail access to buffers for these structural factors (Guidotti-Hernandez, 2010; Loveman & Muniz, 2007; Hajat et al., 2000).

Unlike Latina/o communities, Blacks and African Americans were the targets of forced migration to the US since the 1400s (Clarke, 1990). Health deficits among Black and African American communities have been present since being taken by English, Spanish and French Europeans from Africa and forced into enslavement in the US (Semmes, 1996; Byrd & Clayton, 1992; Frazier, 1957). Scholars state that Africans experienced considerably better social, political and physical health in their communities throughout Africa than they did in the US (Semmes, 1996; Diop, 1987; Rodney, 1972; DuBois, 1915). Scholars have described Africa as having a very diverse array of grains, fruits, vegetables, fish, cattle, milk and animal fats prior to European contact (Semmes, 1996). In addition, multiple forms of social organization among indigenous African nations made certain that communal sharing and food production would thwart the potential for famine or deprivation (Semmes, 1996; Diop, 1987).

Prior to contact with Europeans, agriculture was the principal activity of people in the Western Sudan. Advanced methods of agriculture had been used to domesticate several species of millet and rice (Semmes, 1996). Communities living in the open savannah had specialized in the domestication of animals, including cattle production. Villagers near the Niger River were experts in fishing. Most importantly, various communities throughout Africa had adapted food production to the specificities of their particular environments (Semmes, 1996). Semmes (1996) explains that some West African elders lived to be around 100 years of age. This is longer than average for both the 1400s and contemporary times for Blacks, Africans and African Americans.
The strength and vitality of enslaved Africans and their decedents as an enduring workforce illustrates that the ancestors of Blacks and African Americans had a fortified nutritional base prior to European chattel slavery (Semmes, 1996; Diop, 1987).

Frazier (1957) posits that the expansion of European nations with its methods of extracting wealth through violent exploitation adversely affected African peoples and their ways of life. Semmes (1996) adds that the ways in which European peoples changed the internal social relations of African groups produced a multitude of health problems, including chronic illness and premature death among African communities. Unrestrained violence, superior seafaring weaponry, (Clarke, 1996) and religious intolerance were used to acquire and control the labor of African people. These methods disrupted the organizational and cultural foundations of African life in Africa, en-route to and in the current US (Equiano, 1999; Semmes, 1996).

Byrd and Clayton (1992) and Diop (1987) found that Black Africa supplied up to 100 million souls to the slave trade, with as many as 25 million surviving and enriching the US. Death rates were as high as 50% during wars waged in Africa by Europeans for the capture of African men, women and children to enslave, this includes the rounding up and marching of Africans from the interior to the African coast to be loaded onto European slave ships (Semmes, 1996; Byrd & Clayton, 1992). After being packed like cargo onto enslavement ships, exposure to tuberculosis, measles and unimaginably repulsive living conditions decimated another 15-50% of African people enslaved (Equiano, 1999; Byrd & Clayton, 1992).

It is important to note that death rates listed here are before the slave ships docked at their aspired destination (Byrd & Clayton, 1992). Enslaved African people that were shipped to the US were forced into punitive conditions of being extremely overworked, poor housing, inadequate sanitation, meager food rations with scant to no nutritional value and on-going

During the period between 1732 and 1812, the ideals of freedom and individualism were promoted for all people in the colonies except for Africans, African Americans and Indigenous peoples of the now US. Byrd and Clayton (1992) note that the enslavement of Black people had been a permanent institution for more than 70 years by the time the Declaration of Independence was signed. The myth of the “contented well-cared for slave” was widely promulgated despite the deficit in health outcomes for Blacks, Africans and African Americans enslaved (Byrd & Clayton, 1992, p. 193). The US experienced unprecedented economic growth and tripled in size from 1813-1860 (Byrd & Clayton, 1992). Yet the overall health of Blacks, Africans, and African Americans remained appalling. New dimensions of maintaining the political economy of enslavement changed the health profiles of Blacks, Africans and African Americans. Prior to 1807, the health profiles of Blacks in the US largely consisted of illnesses. The practice of “slave-breeding” changed health disparities in these communities, and they came to predominantly consist of traumatic injuries, childbirth complications and gynecologic diseases (Byrd & Clayton, 1992, p. 194).

England’s abolishment of slavery in 1803 helped to necessitate forced sexual promiscuity among enslaved Blacks and Africans for “slave breeding” in the US by White/Euro-American land and slave owners (Byrd & Clayton, 1992, p. 194). Forcing enslaved Black men, women and adolescents to produce the offspring needed to ensure an ongoing unfree work force was tangibly and intangibly profitable for all White/Euro-Americans (Lipsitz, 1998; Semmes, 1996). The enslaved work force of Blacks, Africans and African Americans was used for the westward

Despite having been granted US citizenship in 1866 (Lee, 2010), the health of Blacks and African Americans during the Civil War and Reconstruction was not much different than it had been in previous years. In the Union Army, Blacks had worse health outcomes than their White counterparts. The War Department never assigned enough doctors to the Black units, leaving Black soldiers to die of wounds that White soldiers recovered from (Byrd & Clayton, 1992). In addition, on-going poverty, poor sanitation, inadequate housing, and lack of access to health facilities combined with epidemics made the Reconstruction period the lowest point of Black health in the US. Byrd and Clayton (1992) explain that the death rates of Black people from the 1870, 1880 and 1890 censuses were so high that the actuaries of both the New York Life Insurance and Equitable Life Insurance companies confidently predicted that Black communities in the US would be extinct by the year 2000.

The same structural factors of poverty, lack of health care, poor sanitation and inadequate housing ushered the deficits in Black health into the 20th century (Semmes, 1996; Byrd & Clayton, 1992). DuBois (2007) documented the life expectancy of Blacks and African Americans in 1900 at 32 years, in comparison to 50 years for White/Euro-Americans. A small, yet growing number of Black doctors, with the support of benevolent societies pioneered and made incredible progress in building Black hospitals and establishing medical schools to serve
the needs of all of the people that came through their doors, including White Americans and especially African Americans. The Black Medical Movement (1788-present) refers to the work of Blacks and African Americans to ensure access to much needed medical care for Black and African American communities during and after enslavement in the US. This movement entails the Black Hospital Movement (1832-1945), the Black Medical School Movement (1868-1910) and the ongoing efforts of medical schools in historically black colleges and universities to keep their open to incoming classes of aspiring Black medical professionals.

The Black Medical Movement (1788-Present)

The Black Medical Movement spans from Blacks and African Americans who practiced as self-taught physicians and pharmaceutical specialists during slavery (Morias, 1970), to the ongoing organizing of the National Medical Association (NMA) and educating of Black physicians at the four remaining Black medical schools in the US (Harley, 2006). Before Blacks built hospitals or established medical schools, benevolent societies, clubs and brotherhoods worked to ensure that the medical needs of African Americans were met (Long, 2012).

Early Forms of the Black Medical Movement: Benevolent Societies, Clubs and Brotherhoods

Before the Reconstruction Era and Jim Crow segregation, Blacks and African Americans had already understood the necessity of working together to provide medical care and political support to their communities (Long, 2012). Prior to the Civil War, freed Blacks and African Americans experienced threats to their safety, health and well-being. In the years after the war, African Americans continued to find themselves denied by law and social custom to the basic elements of citizenship, including the apparatus for and provision of medical care (Long, 2012). Raced-medical practices, the dearth of hospitals – with even fewer that served Blacks, in
addition to a lack of financial resources meant that even simple illnesses could reduce a Black family to becoming destitute (Long, 2012). Long (2012) explains that any attempts from African Americans to receive social welfare or assistance were stifled by the city and private agencies that made no efforts to ameliorate poverty or address illiteracy among African Americans.

Despite having both earned and been bestowed citizenship, Blacks could not depend on the state or federal government to provide a safety net against hunger, disease or from being locked into the margins of society (Long, 2012). Segregation and the violence that it sanctioned, necessitated the starting of Black associations, benevolent societies, clubs and brotherhoods. By forming their own associations, freed Blacks successfully did what they could to provide the needed protection, social support, legal representation and economic assistance that their communities were in dire need of. African-American associations and benevolent societies harnessed the collective power and financial contributions of their members to take a proactive role in articulating the medical needs of and procuring medical care for African Americans.

Organizers of these societies identified that although there were and had always been African American individuals and families that were able to secure the means to provide for themselves, individual efforts alone were not enough to ensure access to structural change or the means of well-being for all African American communities (Long, 2012). Black benevolent societies often helped to finance government agencies and were frequently more effective in providing assistance to African American communities than the federal or municipal authorities (Long, 2012). Long (2012) explains that most of the plans that were conceived by government officials to achieve adequate health care of Blacks failed to generate the needed cooperation and investment that had been achieved by the African American associations. Black benevolent societies organized and administered health care to African American communities. The
Reconstruction Era was crucial for a growing number of Black African Americans working to provide the health care that their communities needed by becoming formally trained as physicians and nurses (Long, 2012). Simultaneously, Black physicians organized professional circles that continue to advocate for the well-being of Black communities, such as the National Medical Association in 1895 (Kennedy, 1933).

**Medical Education for Blacks and African Americans**

Prior to the 1900s, the medical education of Blacks was largely provided by religious organizations and missions (Harley, 2006). During enslavement, a small number of freed Black students acquired formal medical training by traveling to a medical school in Europe or attending a “small cadre” of medical training universities in the east or mid-west of the US (Harley, 2006 p. 1426). Blacks who could not travel to Europe to learn medicine or could not attend formal medical school in the US learned the practice by apprenticeship. James Durham, the first African American physician to receive full medical training by apprenticeship, learned the art of mixing medicines and working with patients from two of his White physician-slave owners (Harley, 2006). Durham was permitted by his slave-owner to purchase his freedom at age 21 and practice medicine in New Orleans, LA in 1788 (Harley, 2006).

The city of New Orleans limited Durham’s practice under the stated rationale that he did not possess a medical degree (Harley, 2006). Requiring that Black physicians have a medical degree from a medical program while most medical programs and hospitals were closed to Blacks is one of three ways that Black physicians were barred from medical practice. Crystallizing herbal medicines as being less effective than allopathic medical approaches kept Black women and men from being able to claim a parity with formally trained medical practitioners, especially with regard to state recognition (Long, 2012). Finally, when Blacks had
received a formal medical education, they were seldom able to the gain hands-on training needed to complete their residency at a hospital, unless it was Black-owned (Gamble, 1995; Rice & Jones, jr, 1994). By the turn of the century, Black benevolent societies and organizations identified that establishing medical schools and hospitals to cater to training African American physicians would enable Blacks to meet the requirements to practice medicine (Long, 2012) and thwart the growing health deficits among Black communities (Rice & Jones, jr, 1994). By 1900, Black and White communities would establish over 40 Black hospitals and 11 Black medical schools nationwide (Rice & Jones, jr., 1994).

**Black Hospitals and Black Medical Schools**

Gamble (1995) makes the distinction that are three types of Black hospitals: White-controlled, Black-founded and demographically-determined. White-controlled hospitals were established by White individuals or organizations and either served African Americans exclusively or had segregated wards where African Americans were treated (Gamble, 1995; Rice & Jones, jr, 1994). Black-founded hospitals were established by Black individuals or organizations to meet the medical needs of African American communities and serve as training centers for Black physicians. Demographically determined Black hospitals are hospitals that were established by Whites to serve White/Euro-American communities but shifted to serving the Black communities that had moved into the area as White/Euro-American moved out (Gamble, 1995). The first hospital established to serve the medical needs of Blacks was Georgia Infirmary in Savannah, Ga, in 1832 and White-controlled (Gamble, 1995).

By 1910, over 100 Black hospitals existed nationwide (Price & Jones, jr., 1994). Despite the significant contributions of White-controlled Black hospitals, the medical care of African Americans at these institutions was generally sub-standard to what was provided to White/Euro-
American patients at other hospitals (Rogers, 2007; Harley, 2006). Rice and Jones, jr. (1994) and Gamble (1995) identify that at Black-controlled hospitals, Black patients were treated with a greater sense of dignity, even when resources were severely limited, as they usually were. In addition, African American physicians were neither hired by nor permitted to train at White-controlled hospitals (Rice & Jones, jr., 1994), even when there was a segregated ward that serviced African American patients (Rogers, 2007). Black-controlled hospitals helped to provide training sites to Black physicians and nurses, even though they were only able to accommodate a fraction of the number of internships that were needed.

Despite coming into existence through monstrous challenges, Black medical colleges and departments worked hand in hand with Black-controlled hospitals to remedy the health deficits that continued to rise among of Black communities. From 1868-1900, 11 Black medical colleges had persevered to provide medical education to aspiring Black physicians (Rice & Jones, jr., 1994) and by 1910, this number would grow to 14 (Harley, 2006). A man named Abraham Flexner would serve the final blow to more than half of these medical programs with the publicizing of his evaluation of US medical schools and his role in implementing the subsequent changes (Long, 2012; Harley, 2006; Savitt, 2006; Price & Jones, jr., 1994). Authors illustrate that despite the perseverance and accomplishments of Black medical programs, medical education for African Americans, in particular, and for medical students in general, was inconsistent and uneven in quality and methods (Long, 2012; Harley, 2007). Savitt (2006) adds that Black medical schools had fared very badly on three evaluations that preceded Flexner’s 1910 report and were feeling pressures to accommodate the new educational demands of the Council on Medical Education (CME) as early as 1904. Of these evaluations, only Flexner’s report had been publicized (Savitt, 2006).
By the time Flexner began working for John D. Rockefeller’s General Education Board in 1912 to implement the CME demands of medical education (Savitt, 2006), little, if anything, had been done to mediate what were already known challenges of Black medical programs (Rice & Jones, jr., 1994). In 1910, there were 14 Black medical schools. By 1912, seven black medical schools were in existence and only had two survived -- Howard University School of Medicine and Meharry Medical College (Harley, 2006). The other seven closed due to the lack of funding that following Flexner’s report (Savitt, 2006). Currently, only four medical schools exist that state in their purpose to train Black medical professionals as a part of their mission. These schools include the two afore mentioned, Charles R. Drew Medical School and Morehouse Medical College (Harley, 2006).

Flexner’s 1910 report portrayed Black medical education as deficient, yet necessary in preventing the spread of illness from Black-diseased-communities to healthy White/Euro-American families (Harley, 2006; Savitt, 2006). This report and Flexner’s subsequent approaches to implementing CME demands to American medical education championed Black medical schools as means of producing Black physicians to take responsibility for the health of the Black race (Savitt, 2006) in place of federal or state level intervention. Flexner’s evaluations and the CMEs demands geared toward constricting access to obtaining a medical degree undermined the efforts of African American communities to gain access to medical training and care. Following the Great Depression, attempts to reduce the health deficits of communities of color through hospital integration (Rice & Jones, jr., 1994) and access to Medicaid/Medicare as a result of the Civil Rights Movement would do little to reverse these trends. However, the efforts and accomplishments of the Black Medical Movement served as the foundation for Civil Rights
organizing against medical discrimination and for medical justice for all people, especially Blacks, African Americans and Latinas/os living in poverty (Nelson, 2011).

Health deficits among Blacks and African Americans have their roots in American slavery. The Black Medical Movement illustrates that these negative health outcomes were maintained by continuing to lock these communities out of receiving the resources for their basic needs that they deserved as a human right, repeatedly earned and continued to fight for access to. The methods of maintaining poor health among Black and African American communities evolved into barring Blacks from medical practice by either thwarting their access to medical school or undermining the legitimacy as a Black medical professionals when they learned the craft by apprenticeship. Keeping Black physicians and medical professionals out of the formal medical industry helped to furnish the medical economy of oppression by constricting its access to White/Euro-American communities; predominantly White/Euro-American males and White/Euro-American families with financial means. The medical needs of Black and African Americans were ignored by the medical profession (Rogers, 2007; Savitt, 2006), while prior to and after the Great Depression, Latina/o communities were focused on by the medical community as being diseased (Molina, 2011) and unfit to have children (Briggs, 2003).

**Black, African American, and Latina/o Health from the Great Depression to the Civil Rights Movement**

During the Great Depression, the health status of all communities plummeted across the nation. Although the Roosevelt administration passed crisis health care legislation for the poor, Black, African American and Latina/o communities were largely locked out of receiving adequate formal health care services due to economic, cultural, language, social and political barriers (Molina, 2011; Galarraga, 2007; Byrd & Clayton, 1992). Even though, by the 1930s
Latina women in Puerto Rico had already had a history of receiving formal medical attention from the medical community in the US, these services were rooted in sterilizing Latina women for eugenic purposes (Guidotti-Hernandez, 2010). Prior to WWII, Mexicans and Mexican American citizens in the US were forcefully repatriated to Mexico by the US government (Molina, 2011; Galarraga, 2007).

Federal policies had attempted to justify Mexican Repatriation under three socially combustive premises: increasing jobs for White/Euro-Americans, saving federal dollars by decreasing the number of needy families requesting assistance (Baderram, 2006) and protecting American citizens from the diseases for which Mexicans were racistly scape-goated as spreading (Molina, 2011). WWII brought the start of the Bracero Program as a means of remedying the shortage of expendable railroad and agricultural labor in the US (Molina, 2011; Galarraga, 2007; Baderram, 2006). The Bracero Program was a collaboration between the US and Mexico to create a guest worker arrangement to bring Mexican men to the US to work in US agriculture and railroads as a means of filling shortages created by WWII (Molina, 2011). Despite these contradictions in, and the eugenic agenda of the health delivery system, fighting in WWII changed Black, African American and Latino expectations of life in the US (National Education Association, 2010; Byrd & Clayton, 1992). Blacks, African Americans and Latinos believed that in their service to their country as soldiers, they had finally earned their right to have access to all the benefits of US citizenship.

During the health care revolution that followed WWII (Ameringer, 2008), almost 90% of White/Euro-Americans were permitted access to health care that was decent, mainstream and appropriate for their medical needs (Byrd & Clayton, 1992). However, Black, African American and Latino soldiers returned home to the same poverty, segregated health facilities and medical
discrimination that locked them out of mainstream appropriate medical care before the war (Byrd & Clayton, 1992). It was not until 1964 and 1965 that legislation would be passed that federally formalized efforts made on grassroots levels (Rice, 2011) to demand access to decent mainstream health care for Blacks, African Americans (Byrd & Clayton, 1992) and Latinas/os (Galarraga, 2007; Ku & Flores, 2005). According to Byrd and Clayton (1992) hospital desegregation rulings in the courts, the Civil Rights Act and Medicare/Medicaid legislation combined to create a new era in health care and health care delivery for communities of color. These advancements were very significant in Latina/o communities since they provided federal mandates for language translation of medical forms, recommended procedures, and medication instructions among other things (Ku & Flores, 2005). Medicaid and Medicare legislation provided Blacks, African Americans and Latinas/os access to this basic health care necessity for the first time since the birth of the medical profession in the US (Molina, 2011; Byrd & Clayton, 1992). None of these achievements would have been possible without the National Medical Association and its communities organizing activist tactics (Byrd & Clayton, 1992).

The Bracero program was dismantled at the same time of these advancements in access to health care among Black, African Americans, and Latina/o communities in the US. Throughout its tenure, Mexican farm workers had repeatedly filed complaints about the work camps of the Bracero program as being overcrowded, having too few toilets and a lack of facilities for workers to bathe and wash clothes (Molina, 2011). While Mexican day laborers were being deported to Mexico at the close of the Bracero program, affluent Cuban families fleeing Castro’s coming to power were offered permanent residency in the US if they were already living within its borders (National Education Association, 2010). The Cuban families that immigrated to the US during the 1960s were middle/upper-class, with most having the lighter skin-tones that were favored by
White/Euro-Americans (Hajat et al., 2000). No other immigrant or communities immigrating to the US have been extended such an invitation before or since the Cuban Accommodation Act (National Education Alliance, 2010; Hajat et al., 2000). Affluent Cuban families were offered permanent residency, while Mexicans/Mexican Americans were deported and Puerto Rican women continued to be experimented upon.

The difference in the way that each of these Latina/o communities is given or barred from access to the US illustrates how their interests were maneuvered against each other for the maintenance of a racial hierarchy, and industry access to their expendable labor. Molina (2006; 2011) points out that wretched living conditions among the workers camps that were supported by federal programs were maintained by the same ruling body that was enacting legislative policies to eradicate the diseases that these substandard conditions spawned. The consequences of maintaining a racial hierarchy manifest itself through the health disparities present among Black, African American and various Latina/o communities in the US.

Improvements in the health status among communities of color in the US achieved by Civil Rights legislation lasted only ten years before plateauing in 1975 and (Byrd & Clayton, 1992) continuing down-hill thereafter (Wheeler et al., 2010; Washington, 2006), except for Cubans (Galarraga, 2007; Hajat et al., 2000). However, these achievements illustrate that disproportionate health disparities among Black, African American, and Latina/o communities are correctable in large part, through expanding access to appropriate, quality medical care in addition to remedying poverty, increasing access to decent housing and providing jobs that pay a livable wage (Molina, 2011; Guidotti-Hernandez, 2010; Washington, 2006; Byrd & Clayton, 1992). In other words, if we correct socio-economic and public health disparities, HIV/AIDS incidence among Blacks, African Americans and Latinas/os can decrease.
The health deficits present among Black, African American, and Latina/o communities from the times of enslavement, throughout immigration and acculturation continue to be the biological product of oppression created by structural factors (Shulz & Mullings, 2006). Numerous scholars illustrate the direct relationship between the needs of a market based society in the US and the political economy of poor health outcomes among Blacks, African Americans and Latinas/os (Hadden, in press; Jackson & Cummings, 2011; Lara et al., 2005; Semmes, 1996; Williams, 1994; Byrd & Clayton, 1992). Semmes (1996) describes this relationship as “antibiosis”; where the association between two organisms adversely affects or is injurious to one (p. 24).

Indigenous peoples throughout Africa and the Americas greeted European explorers and sea merchants as honored guests (Semmes, 1996). Shortly thereafter, Europeans took the land of African, Native American, Mexican and Puerto Rican Indigenous peoples and targeted them for enslavement and or genocidal policies. Frazier’s (1957) research illustrates that changes in plant and animal life, biological conflict and the dismantling of sustainable forms of social organization followed along the same path of where European settlers developed colonies. The European process of cultural and environmental inversion was (Semmes, 1996) and continues to be global (Prashad, 2013). The quest for wealth and new lands among European merchants, slave traders and slave/plantation owners produced an antagonistic relationship with Indigenous Africans in Africa, and North American and Mexican First Nation peoples in the US. Antibiosis emerged as a consequence of the methods of extracting wealth, acquiring labor and environmental manipulation practiced by European entrepreneurs and settlers. These methods were brought with them to the “new world” (Clarke, 1996; Semmes, 1996, p 17). African
enslavement by Europeans produced additional health deficits for Blacks, Africans and African Americans, in particular (Semmes, 1996).

Poor health outcomes form monumental obstacles to group development, survival and well-being among communities of color in the US (Semmes, 1996). The trajectory of health problems and high mortality rates among Blacks, African Americans and Latinas/os in the US have formed the foundation for current health crises, including disproportionate rates of HIV/AIDS (Wheeler et al., 2010; Washington, 2006; Semmes, 1996). According to Semmes (1996), past and contemporary cultural and institutional disruptions produced by systemic inequality impedes “the normative pursuit of health” and community well-being (p. xii). In addition, the Black Medical Movement illustrates, that the notion of racial equality is a myth (Rogers, 1917) and that structural barriers have created the differences in health outcomes along racial lines.

The social problem of disproportionate HIV/AIDS rates among communities of color in the US is contextualized within the larger structural problem of historic and on-going cultural oppression or antibiosis. This oppression is rooted in the evolution of the various methods of social, economic and political control used in the extraction of resources from Black, African American and Latina/o communities (Semmes, 1996). Health deficits are both a product and function of oppression. The medical field has historically been complicit in and profited from the maintenance of disproportionate health deficits among people of color in the US (Washington, 2006). The medical profession generated financial support for and established itself through offering a pseudo-scientific basis for the biological inferiority of Black, African American and Latina/o people (Byrd & Clayton, 1992).
The Medical Economy of Race Based Oppression and HIV Prevention

Byrd and Clayton (1992) identify that the medical profession instituted and professionalized itself by participating in the development of a mythology of racial inferiority. Offering what was posited as scientific proof that the color of a person’s skin was indicative of their capacity to fight off diseases gave the burgeoning medical profession more credibility in influential social and political circles. More credibility and authority enabled the medical establishment to corner the market of health, while commodifying its services for well-being.

The development of the medical profession in the US took shape within the contradiction of the new nation’s creed that “all men are created equal” alongside the abominable realities of enslavement and mass genocide of indigenous peoples in the US and Mexico (Molina, 2011; Byrd & Clayton, 1992, p 193; Rogin, 1971). Despite Imhotep and his work in Egypt being the first medical practices in history of note, European doctors in the colonies only saw African patients (free and unfree) if forced to by White/Euro-American slave owners or judicial forces (James, 2005; Carew, 1996; Byrd & Clayton, 1992). By the mid-1700s, the foundations of racial inferiority were laid with the writings, research and accounts of physicians who were well-known throughout the colony (Byrd & Clayton, 1992). Doctors erroneously categorized Blacks, African Americans and Indigenous Nations as subhuman objects that were an undeveloped mutation of Europeans and White/Euro-Americans (Omi & Winant, 1994; Byrd & Clayton, 1992). This idea was used to justify the enslavement of Blacks, Africans and African Americans and asserted as being based on medical scientific fact (Omi & Winant, 1994; Byrd & Clayton, 1992).

During the 18th century, cultural and social forces evolved to create the roots of public assistance and academic health-care delivery. Following Europe’s lead, religious and non-
religious organizations collected and distributed private funds to help to ameliorate poverty and the hardships of abandoned married women with children (Igra, 2007; Trattner, 1999). Some of these organizations built and managed poorhouses, almshouses and pest-houses throughout the US (Trattner, 1999; Byrd & Clayton, 1992). Simultaneously, changes in medical training required that students have access to “patient material” as a new part of their medical education (Byrd & Clayton, 1992, p. 194). By the dawn of the 19th century, the role of Blacks and African Americans in receipt of health care shifted from rarely being seen by physicians in the colonial period, to being made the experimental and training material for hands-on practice for medical school students (Washington, 2006; Byrd & Clayton, 1992).

Alms houses, poorhouses and asylums evolved into city hospitals (Dowling, 1982), carrying with them the exploitative and indifferent medical practices of the teaching hospitals (Byrd & Clayton, 1992). Several of the teaching hospitals founded during this time are the ancestors of present tax-supported hospitals, which continue to disproportionately serve low income communities of color in comparison to privately funded medical centers (Ginzberg, 2000; Byrd & Clayton, 1992). Carrying over the same medical practices of the city and teaching hospitals helped to solidify the flawed “White Doctor-Black patient” relationship (Byrd & Clayton, 1992, p 193). In most instances, doctors relieved themselves of following the ethical codes of the medical profession when working with Black, African American, low-income (Byrd & Clayton, 1992) and after 1848, Mexican and Puerto Rican patients (Molina, 2011; Guidotti-Hernandez, 2010).

The medical profession adapted the health system to the contradictions of the new nation’s peculiar institutions of enslavement and genocide. At the same time, Americans were developing a worship of a new culture of “reason” that promised to liberate humanity and all
diseases of the body and mind (Byrd & Clayton, 1992; Starr, 1982, p. 3). The investment in this new culture of science increased medical authority and permitted it to monopolize the market of remedying dis-ease (Byrd & Clayton, 1992; Wenocur & Reisch, 1989; Starr, 1982). In exchange, the medical profession intensified its efforts to justify the racial inferiority of Blacks, African Americans, and Indigenous peoples in the US, Mexico and Puerto Rico (Molina, 2011; Washington, 2006; Byrd & Clayton, 1992).

As early as the 18th century, physicians had established a lexicon of diseases that had lacked scientific basis and were specific to Black, African and African American communities (Byrd & Clayton, 1992). This practice would be repeated in years to come with Black women and men active in the struggles for civil rights (Metzl, 2010). Leading physicians from 1813-1860 continued to pseudo-scientifically document the biologically-based supremacy of White/Euro-American. Racial inferiority was taught at the nation’s top medical education programs, including the University of Pennsylvania (Byrd & Clayton, 1992). This was the dawning of scientific racism. Legitimizing biological inferiority by the cultural, non-scientific notion of skin-based racism set the socio-political stage for physicians, investors and law makers to justify a genocidal expansion into the south west region of the Americas as the Manifest Destiny of the US (Molina, 2011).

Concomitantly, the American Medical Association (AMA) had expanded to control post graduate and professional training, state medical licensing and the pharmaceutical industry (Starr, 1982). Science had disproven any scientific basis of racial inferiority by the 1920s and 1930s. However, the AMA continued in its assistance in creating, legitimizing, passing, enacting and enforcing racist legislation (Byrd & Clayton, 1992) and demeaning public health practices (Molina, 2011). Byrd and Clayton (1992) explain that by 1930, organized medicine defeated
over 20 pieces of health care legislation that Blacks and African Americans would have greatly benefited from. The notion that immigrants were more likely than White/Euro-American citizens to spread diseases shaped immigration, housing and labor policies, and individual-level conflicts (Molina, 2006; 2011). The pliability of racist logic enabled immigrants to be targeted simultaneously as a drain on federal monies, threats to public health and sources of expendable labor (Molina, 2006; 2011; Washington, 2006).

Mexicans applying to work as day laborers in the US through the Bracero program (1942-1964) were required to be examined by physicians in Mexico and the US (Molina, 2011). This requirement was in accordance with railroad company regulations and US immigration policy (Molina, 2011). US medical officials examined the psychological profiles of all of the “prospective braceros”, while screening them for tuberculosis and venereal diseases (Molina, 2011, p. 1027). The physicians checked the bodies of the Mexican men for scars and calluses; fresh scars could disqualify an applicant (Molina, 2011). The prospective Braceros found examinations long, tiring, humiliating and attacking (Molina, 2011). Mexican men waited anywhere from six to ten hours to be examined by a medical official. The examination rooms held as many as 40 men at a time, where they were required to remove all clothing and undergo the physical tests in English (Molina, 2011). Recruits underwent another compulsory physical examination when they arrived at the Bracero worker camps in the US (Molina, 2011). Any small imperfection that the medical official found or fabricated during the physical examination could result in the applicant being disqualified from the program and deported back to Mexico (Molina, 2014).

Contradictory to the rigorous medical examination before and after arriving in the US, the living conditions for the workers at the Bracero camps were deplorable (Molina, 2011).
Employers did not adhere to providing safe living or working conditions for Mexican day laborers (Molina, 2011). Workers frequently filed complaints about inadequate accident and health insurance, and unsanitary housing conditions (Molina, 2011). Most workers ultimately contracted typhus, tuberculosis and or lice. Health officials responded to these out-breaks by using cyanide to destroy the lice or deporting sick workers back to Mexico (Molina, 2011). According to the medical professionals, poor personal hygiene, rather than the structural problems of the rancid living conditions in the Bracero worker camps, was the cause of the spread of these bacteria among workers (Molina, 2011). The forced sterilization of Black, African American and Latina women and men is another example of medically remedying social problems that were defined through a racist lens (Guidotti-Hernandez, 2010; Gutierrez, 2008; Byrd & Clayton, 1992).

In the early 20th century, an array of compulsory sterilization laws were passed in 50 states throughout the US and Puerto Rico (Briggs, 2003; Byrd & Clayton, 1992). Hysterectomies were performed on Black, African American and Indigenous women, Latinas and women from low-income communities without their knowledge or permission (Committee for Puerto Rican Decolonization, 2014; Guidotti-Hernandez, 2010, Gutierrez, 2008; Byrd & Clayton, 1992, p 196). Hysterectomies performed on Black and African American women would come to be jokingly referred to as “Mississippi appendectomies” among medical professionals and personnel (Byrd & Clayton, 199, p. 196). Women of color were sterilized at routine doctor visits, after having given birth or by being coerced to sign documents consenting to the procedure in exchange for receiving public assistance (Committee for Puerto Rican Decolonization, 2014). Medical officials and state-level administrations utilized forced sterilization as a means of keeping communities that were defined by politicians as being socially
and economically unfit from having children. It was rationalized that by having children, these ‘unfit communities’ would pollute White/Euro-American middle/upper class gene-pools (Committee for Puerto Rican Decolonization, 2014; Gutierrez, 2008). Despite what may have been liberatory intentions, W. E. B. DuBois supported lawfully enforced sterilizations for Blacks and African Americans living in poverty as an opportunity to further develop the quality of the Negro race rather than prematurely increasing its quantity (DuBois, 1932). The medical field, and its supporters, openly advocated and participated in instituting individualized medical approaches to ameliorating problems that were caused by structural factors.

Medical approaches to addressing social problems was specifically tailored to the racist beliefs about Mexicans, Mexican culture and the problematized fertility of Black, African American and Latina women (Roberts, 1996). Washington (2006), Guidotti-Hernandez (2010) and Galarraga (2007) identify that the mythology of racial inferiority that the medical field helped to affirm continues to permeate current medical ideologies and practices with Black, African American and Latina/o patients. The health deficits present among Blacks, African Americans and Latinas/os support the maintenance of the medical field its medical economy.

Disproportionate health deficits among Blacks, African Americans and Latinas/os position them as a market for pharmaceutical companies for various medications. The pharmaceutical market is funded by the demand for medications, which consequently entails high rates of fear/likelihood of contracting a disease or infection. In addition, health deficits provide a pool of research participants for experiments and trials for exploring new drugs (Washington, 2006). Disproportionate rates of HIV/AIDS in communities of color have created a mass of Black and African American children born with AIDS, who have also been orphaned by AIDS. Currently, these children serve as the primary pool of research subjects in HIV/AIDS
studies (Washington, 2006), whereas during the onset of the infections, people of color were prohibited from participating in clinical trials (Kull, 2010). Additionally, unethical experimentation on Blacks, African Americans and Latinas/os persists (Molina, 2011; Guidotti-Hernandez, 2010; Washington, 2006; Briggs, 2003; Byrd & Clayton, 1992). The medical profession continues to maintain its legitimacy through the expansion of these health deficits by developing medications to treat these illnesses. Medication is limited, if not less effective than primary prevention (Giami & Perrey, 2012). Pandemic HIV/AIDS rates – which themselves were created by ignoring HIV/AIDS in Black, African American and Latina/o communities – have added to the call to medicate HIV/AIDS risk rather than addressing of the structural-drivers of this infection, such as poverty, incarceration and homelessness.

**The Political Economy of Oppression: Maintaining Disproportionate HIV/AIDS Prevalence among Black, African American, and Latina/o Communities**

The political economy of oppression refers to the perpetual maintenance of social disintegration within marginalized communities as a means of upholding social, political and economic dominance by communities that are a part of or benefit from the status quo. Status-quo communities maintain their position through the construction and use of societal polices that disproportionately ration resources in their interests. These resources include access to public assistance, legitimate employment that pays a livable wage, opportunities for advancement, accessible healthy food options, decent housing and access to quality health care.

Rationing opportunities for status-quo communities to have more than what is needed for their basic needs to be met comes at the expense of marginalized communities having less than what is needed for their basic well-being. It is this disproportionate allocating of who is permitted to have their basic needs met and who is denied basic necessities that creates the
conditions for disproportionate rates of HIV/AIDS in the US to exist (Semmes, 1996). HIV/AIDS rates are catastrophically high in communities living in or close to poverty. HIV/AIDS rates in Black, African American and Latina/o communities were either ignored as a means of protecting a status quo or not focused on in a way that protected a status quo. Approaches to public health in and outside of communities of color continue to be measured by profit, financial expenditure, the political economy of race-based oppression, and the possessive investment of Whiteness (Lipsitz, 1998).

HIV/AIDS prevention approached in these ways has done more to reinforce how communities of color are stratified in a state of poor, substandard health than it has to uphold the constitutional responsibilities that the US has to its citizens (Guidotti-Hernandez, 2010; Lee, 2010; Washington, 2006; Semmes, 1996). The creation of a health-care system for second-class status, experimental and training purposes was established at the expense of the health and well-being of communities of color in the US (Molina, 2006; 2011; Guidotti-Hernandez, 2010; Semmes, 1996). The complicity of the medical field in profiting from practices that produced health deficits illustrates what can be understood as preordained negative health outcomes for communities of color as a means of securing professionalization and the maintenance of the status of the medical field (Molina, 2011; Semmes, 1996; Byrd & Clayton, 1992; Starr, 1982; Chase & Knopf, 1977). Investing in the health deficits of one group, while permitting buffers to support positive health outcomes for another group, can lead to disastrous national and ultimately global consequences.
Social Disintegration among Communities of Color: A Pathogenic Pathway of Increased National Communicability

Social disintegration is the dismantling of the structural-level supports of individual, family and community well-being. Enforcing of criminalizing injustice policies, defunding public assistance programs and on-going un/under-employment have expanded socioeconomic inequality, particularly among low-income Blacks, African Americans and Latinas/os (Alexander, 2012; Friedman, Cooper, Tempalski, Keem, Riedman, Flom & Des Jarlais, 2006; Blakenship, Smoyer, Bray & Mattocks, 2005; Iguchi, Bell, Ramchand & Fain, 2005). Wallace (1991) identifies that the public policies that have reinforced socioeconomic inequality, have also functioned to disrupt the traditional social networks that have enabled Black, African American and Latina/o communities living in or close to poverty to survive (Wallace, 1991).

Social networks are defined as a set of person-to-person links through which information is shared, social support is accessed and socialization to group norms takes place (Friedman, Mateu-Gelebert, Curtis, Maslow, Bolyard, Sandoval & Flom, 2007; Pilowsky et al., 2007). Friedman and colleagues (2007) identify that in working-class communities, social networks are especially significant in the development of belief systems, activities and community-level organizing necessary to navigate the day-to-day challenges of living in or close to poverty. For families living in or close to poverty in the same geographical area, social networks provide resource sharing and strategies that are essential for survival and community stability (Wallace, 1991).

Disproportionate incarceration removes parents and relatives from the reach of their families and places them in controlled environments. This controlled environment is often a costly distance from the familial supports of the family member or family members being
incarcerated (Arditti, 2005). The family members incarcerated are often caregivers and wage earners of their families and communities. The incarceration of individuals leaves their families with fewer supports to access and share among their social networks (Arditti, 2005). Similarly, fewer opportunities to earn a livable wage or acquire public assistance while underemployed or looking for work also translates into fewer resources to utilize or share among these networks. The deregulation and defunding of social services continue to work in synergy to create the conditions where social networks are no longer able to function to support people working to meet their basic needs (Wallace, 1991).

Social network members influence each other’s behavior, including sexual and HIV-risk taking (Pilowsky et al., 2007). How HIV risk-behaviors take place is largely contingent on local customs, which in turn, are necessitated or constrained by structural-factors (Wheeler et al., 2010). Wallace (1991) explains that among low income-communities of color, needle sharing or unprotected sex serve as coping strategies for navigating environmental conditions that necessitate HIV risk-behaviors en-route to survival. These coping mechanisms are a means of navigating disintegrating access to decent affordable housing (Wolitski, Kidder & Fenton, 2007), legitimate employment (Wheeler et al., 2010), and protection from the effects of harmful stigma (Medina, 2009; Berger, 2005) and/or punitive criminalizing policies (Friedman et al., 2006). Concomitantly, catastrophic and disproportionate rates of HIV/AIDS in Black, African American and Latina/o communities are the biological footprint of long-term social disintegration caused by dismantling public supports (Wallace, 2002). An explosively rapid spread of HIV is inevitable within a geographically concentrated area where HIV risk-taking is necessitated by structurally controlled factors (Wallace, 1991).
Social disintegration has significantly weakened social networks among low-income communities of color. Disintegrated socioeconomic supports and disproportionate incarceration have helped to create environmental constraints that necessitate survival strategies that are also HIV risk-behaviors. Disproportionate incarceration fed by criminalizing injustice, defunded public assistance and ongoing unemployment induce a mass out-migration of youth and adults in search for better opportunities (Wallace, 1991) or en-route to being transferred to an incarceration facility (Alexander, 2012). Catastrophic HIV/AIDS rates as a result of social disintegration can be both the outcome and cause of mass out-migrations of individuals unaware of their serostatus to communities that imagine themselves to be unsusceptible to HIV (Wallace, 1991). Wailoo (2011) and Wallace (1991) illustrate that historically, it has always been a matter of time until viruses cross into geographical areas that are imagined to be protected by social distance. Ultimately, approaches to thwarting disproportionate HIV/AIDS rates that do not address structural factors, such as disproportionate incarceration, need for decent affordable housing, stigma, dismantling of public assistance and chronic un/underemployment, fortify the pathway from social disintegration to increased national and even global (Kanki & Essex, 2000; Chirimuuta & Chirimuuta, 1989) communicability.
CHAPTER III: SOCIAL WELFARE POLICY AND HIV/AIDS

Initial Responses to HIV Risk in Black, African American, and Latina/o Communities

Policy Initiatives toward HIV Prevention

Black, African American and Latina/o communities have been and continue to be disproportionately affected by the HIV pandemic since its onset (Albion Street Centre, 2012; Kaiser Family Foundation, 2009; Washington, 2006). Selik, Castro and Pappaioanou (1988) identify that Black, African American and Latina/o communities demonstrated disproportionate rates of HIV and AIDS infections as early as 1986. However, it was not until 1996 - ten years later - that communities of color in the US were identified by the federal government via the presidential administration as illustrating the highest numbers of AIDS infections in the country (amFAR, 2012; Argon & Kates, 2004). Two years later, in 1998, the Clinton Administration declared HIV rates among Black African Americans to be a national crisis (amFAR, 2012). This was more than ten years after experts had already identified these communities to be at a disproportionately higher risk than the rest of the US population (Selick et al., 1988). Reflective of how and when HIV in Black, African American and Latina/o communities was named as a social problem, the Minority AIDS Initiative (MAI) was created. MAI was a part of the Department of Health and Human Services’ larger initiative to eliminate racial disparities in health outcomes (Sutton et al., 2009).

The MAI was officially made into law in 2006 as a part of the Ryan White Treatment Modernization Act (Sutton et al., 2009). This initiative provides targeted funding to federal agencies that are working to reduce HIV/AIDS disparities among communities of color (Sutton et al., 2009; Aragon & Kates, 2004). Through this funding, the initiative has also created
opportunities to expand community-level capacities to serve people of color who are most at risk of contracting or are living with HIV/AIDS (Sutton et al., 2009; Aragon & Kates, 2004). The MAI has been a resource for HIV/AIDS treatment, individually-based HIV prevention and HIV/AIDS research.

In 2003, the Centers for Disease Control and Prevention (CDC) identified early diagnosis and treatment of HIV as being vital components of combating the epidemic in Black African American and Latina/o communities (Sutton et al., 2009). This same year, the CDC launched the Advancing HIV Prevention Initiative (AHPI) (Sutton et al., 2009). The focus of AHPI is to work specifically with people that test positive for HIV as a means of further decreasing HIV transmission (Sutton et al., 2009). AHPI consists of four strategies for HIV prevention. These strategies include: ensuring HIV testing to become a routine part of medical care; increasing the availability of non-medical HIV testing locations as a means of encouraging people to become aware of their status; working with people with positive-serostatus and their partners as a means of increasing prevention efforts and recommending routine opt-out HIV screening during prenatal care (Sutton et al., 2009). The implementation of the initial projects of the AHPI focused on communities with a high percentage of Blacks and African Americans. The CDC continues to partner with and fund community-based programs that provide culturally sensitive information on methods of safer sex and expand testing (CDC, 2011).

**Accomplishments and Limits of This Response**

On a ground level, the programs that were funded by the MAI and the AHPI accomplished expanding HIV testing through offering testing at non-medical sites and access to medical care for people with seropositive status. Funding from these initiatives support collaborations between the CDC and community-based organizations to create greater access to
information about evidence-based methods of HIV prevention. These accomplishments reflect the goals of the CDC. The goals of the CDC had predominantly been to educate people/the public about HIV/AIDS; to promote and create access to testing as a means of early diagnosis; and to promote and create access to preventative services to people with seronegative status and access to treatment for people with seropositive status (Sutton et al., 2009). If the expected outcomes of these goals are to educate, test and treat, which have been seen as community-based versus individually-based, then this approach has mostly been a success.

If the goal is to curtail HIV rates in Black, African American and Latina/o communities, then the on-going alarming HIV rates are illustrating that this approach is lacking something. Authors identify that what may be missing is a component to address structural factors of poverty, incarceration, homelessness and joblessness (Auerbach et al., 2011). Structural factors contribute to community and individual-level conditions that serve as vectors for HIV transmission (Phelan, Link & Tehranifar, 2010). Additionally, macro-level factors cannot be covered by condoms or mediated by early detection.

The Scope of HIV/AIDS in the US as a Social Problem

Problematizing Gay Sex

In its onset, the virus that came to be known as the cause of HIV/AIDS was not considered to be a social problem by the Reagan Administration, public opinion, the news media or among select influential medical and academic circles. When the pandemic struck in American communities, the influence of the CDC had already been weakened by a series of aggressive budget cuts. The tenure of a right wing administration led the naming of the problem to be deviant behavior (Washington, 2006) instead of an infectious pathogen on a public health
infrastructure wilted by defunding (Snowden, 2008). The very first publications and media coverage about this mysterious pathogen highlighted that a rare cancer had been found, but solely among homosexuals and injection drug users (amfAR, 2012). Thus, identifying the existence of AIDS as a problem was the simultaneous marking of the problem as being a disease of deviant behavior. When Ryan White and Kimberly Bergalis died, they were identified as being “innocent victims” of AIDS (Washington, 2006, p. 331, emphasis added).

Use of this language further implied that there indeed were guilty victims (Washington, 2006) who were responsible for their own god-ordained fate of sero-positivity (Chirimuuta & Chirimuuta, 1987). By the late 1980s, AIDS had spread to communities that had been previously imagined to be immune, these communities included heterosexual White/Euro-American men, women and children. Venomous anti-homosexual hysteria escalated to hateful claims-making that White/Euro-American gay males were sources of the pathogen and that their behavior needed to be contained as a public health measure (Washington, 2006). The silence of the Reagan Administration, followed by the blocking of federal aid for AIDS prevention to organizations that served gay communities, effectively sent the message that the social problem was not an infectious pathogen but gay sex - the assumed sexual practices believed to be inherent among men who had sex with men, where the pathogen had been most frequently found.

Spector and Kitsuse (1973) define a social problem as the process by which a collective defines a reputed condition as being socially problematic through claims-making and the assertion of grievances. If AIDS was defined as a social problem, it was because the behaviors assumed to be encompassed in gay sex were also believed to be the habitat of the pathogen. Thus, it was gay sex that was believed to be putting the nation at risk and what needed to be controlled, not the pathogen. By 1982, cases of AIDS had been reported among women, infants
and recipients of blood transfusions. However, it was the increasing numbers of AIDS cases among gay communities that generated the most public attention (Washington, 2006).

Gay communities and ‘innocent victims’ were the only communities that had public visibility with AIDS. Despite this visibility, White/Euro-American gay communities, like communities of people that injected drugs and people of color, were not in a position of political power to identify the problem or name possible solutions in a way that would garner access to mass social support. Unlike gay communities, communities of color and people that injected drugs were either deemed hopeless and not worth the investment (Osborn, 1986), or were seen as lazy and unintelligent, and not worth the investment of resources (Fumento, 1990) or were simply ignored by news media and government offices (Wheeler et al., 2010). Gay communities, like European immigrants in the 1860s, were vilified, yet seen by social welfare institutions as being more salvageable than communities of color and people that injected drugs. It also helped gay communities that gay scholars and academics often agreed with and supported suggestions that AIDS was primarily a Black problem (Chirimuuta & Chirimuuta, 1987), even though the grassroots organizing of gay communities challenged political inaction regarding AIDS in numerous marginalized communities (Kull, 2010).

According to Spector and Kitsuse (1973), the process by which a social problem is formulated, presented and addressed consists of four stages. When the public asserted that sex among gay communities was problematic in spreading AIDS throughout the nation (Washington, 2006), AIDS as a social problem, named through gay sex, was its first stage. Stage two began with the formal response to AIDS. In 1987, President Reagan referenced AIDS for the first time during his presidency and since the onset of the virus (Kull, 2010). That same year, the CDC launched a nationwide public information campaign that was titled “America Responds to
AIDS” (amfAR, 2012, p. 3). Simultaneously, Republican Senator Jessie Helms introduced a bill that prohibited any organizations that served gay communities or “promoted homosexuality” from receiving AIDS prevention funds (Kull, 2010 p 4). Gay communities responded to these social and political actions by organizing grass roots reproaches to this formal response to AIDS. In taking organized grassroots political action, these communities made claims and demands that expressed a strong sense of dissatisfaction with the official response to the conditions of AIDS care or lack thereof. Spector and Kitsuse (1973) identify this as stage three of the formulation of a social problem.

In stage four, institutions were established that are alternative, parallel or counter to the formal institutions that were initially charged with the responsibility of remedying the harmful conditions (Spector & Kitsuse, 1973). As Kull (2010) identifies, grassroots organizing led by community advocacy groups, such as the Gay Men’s Health Crisis (GMHC), ACT UP and the AIDS Project Los Angeles (APLA) made gains in US health-care delivery that improved the service of Lesbian, Gay, Bisexual, Transgender, Queer & Questioning people, women and people of color. These changes also included important shifts in the ways that federal agencies, such as the FDA engaged in research and approval of medications through the clinical trial process (Kull, 2010). However, Washington (2006) identifies that these gains did not last as long in other marginalized communities as they did for gay, middle class and White/Euro-American communities.

HIV/AIDS: A Black Disease

Ten years after the debut of AIDS in a presidential speech, visibility had shifted from gay communities and homophobic public fears to the mass of Black, African American and Latina/o survivors of this disease. By 1997, AIDS rates in gay White/Euro-American communities were
declining. However, in Black, African American and Latina/o communities, the rates of this disease were on the rise and comprised 41% of all AIDS cases (amfAR, 2012). Throughout the 1980s and early 1990s, newspaper stories and research findings that identified people of color as growing among the numbers of people infected with and dying of AIDS-related causes were given very little prominence (Washington, 2006). Lowering rates of AIDS in gay White/Euro-American communities, coupled with the exploding rates in communities of color now made this public health crisis in these communities front-page news (Washington, 2006).

One year prior to the visibility of HIV/AIDS’ victims of color, conservative legislation that vividly blamed Blacks and African Americans for welfare dependence had been passed during a democrat administration. This legislation was campaigned using the reified stereotypes of Black, African Americans and Latinas/os as lacking morals, being shiftless, lazy, sexually uninhibited and reproductively irresponsible (Roberts, 1997; Scott, 1997). The historicity of these images effectively lent itself to HIV/AIDS being interpreted by the public and federal agencies as transmuting from a gay disease to being a black disease. Claims-making about and the actuality of the alarming rates of HIV/AIDS in Black, African American and Latina/o communities has been key in maintaining a steady, although lessening flow of funding into prevention initiatives in communities of color (Sutton et al., 2009).

Most of these prevention initiatives utilize behavioral change models that are individually focused (Wheeler et al., 2010). These approaches are aimed at promoting increased testing and condom use among communities of color as though it is their sexuality that is the problem and not the high-risk social structure to which they are yoked. Thus, individually rooted methods of HIV/AIDS prevention and program delivery may be doing more to affirm recycled racist, sexist and classist stereotypes of Black African American and Latina/o sexuality, than
they do to drastically reduce HIV/AIDS prevalence in these communities. As it seems, condoms cannot hold a history of oppression, but they can up-hold a race and class based hierarchy.

Utilizing the analysis that Spector and Kitsuse (1973) have offered, HIV/AIDS in Black African American and Latina/o communities in the US is in the third stage of social problem formulation development. In this stage, the formal response from the agencies that have been charged with the responsibility of remediaying the prevalence of HIV/AIDS in communities of color is being challenged. Experts such as Auerbach et al (2011), Wheeler and colleagues (2010) and Wallace (2007) have been instrumental in the conversations and discourse to include a structural approach to HIV/AIDS prevention among Black, African American and Latino communities. A structural approach could address environmental and contextual factors that constrain individual choice-making related to HIV risk behaviors (Auerbach et al., 2011; Auerbach, 2009). Some of these factors include poverty, institutionalized oppression and racism, disproportionate incarceration rates, criminalizing justice, homelessness and chronic joblessness. The next step will be to set up institutions, informal or formal, that incorporate this approach and are inclusive of the contexts within which HIV risk behaviors among Black, African American and Latina/o communities take place.

Identifying Africa as the source of this pandemic has been crucial in the naming of HIV/AIDS as a black disease. The continent of Africa has been and continues to be posited within prominent medical and social science circles as being the location from where HIV has originated from (Pepin, 2011). Although such beliefs have been and continue to be widely accepted, they are also vehemently and factually refuted. Chirimuuta and Chirimuuta (1987) have anchored this conversation and add to it that from the first formally identified cases of AIDS, through to 1987, the US accounted for more than 70% of the world’s AIDS cases.
Seeking to elucidate the venomous anti-gay response to AIDS in the 1980s, Kull (2010) suggests that the ongoing absence of a clear and scientific understanding of AIDS enabled the disease to be made sense of as a metaphor for punishment for perceived deviant and immoral behavior.

Kull’s (2010) analysis becomes untenable when it is considered that over 30 years into the pandemic and post a clear scientific understanding of HIV/AIDS, approaches to prevention in communities of color continue to be fueled more by antiquated stereotypes of exotic, Black, African-American and Latina/o sexuality than by a human rights agenda (Poindexter, 2010). Chirimuuta and Chirimuuta (1987) and Schneider and Ingram (1993) explicate that when a political figure seeks to dissociate his country from the problem, a political administration must create a target group population as the source of the problem. This target group can also serve as the market for the prescribed solutions of the problem (Rodney, 1982). In this instance, the Black African and Black African American connection becomes extremely useful, particularly when considering the compelling evidence that in its onset, it was the US and France that exported AIDS throughout the world (Osborn, 1986), not a country state of Africa (Chirimuuta & Chirumuuta, 1987).

The History of HIV and AIDS in the US

Eradicationism: The Dismantling Before the Storm and Its Influence on National Communicability

Frank Snowden (2008) found that in 1969, US Surgeon General William Steward reported that it was time to close the book on infectious diseases. Surgeon General Steward’s remarks were reflective of the then popular idea of *eradicationism*. Eradicationism purported that medical science had the ability to eradicate infectious diseases from the earth. This view gained popularity in the US as early as 1948 (Snowden, 2008). However, eradicationism waned
in 1992 when the maturation of the HIV/AIDS public health crisis made it virtually untenable, even to the most convinced of right-wing administrations.

Three key factors led to the rise of the idea that science had the ability to eradicate infectious pathogens from the earth (Snowden, 2008). By mid-century, science had developed vital weapons against infectious diseases. These developments included penicillin and streptomycin, which provided the means to treat syphilis, staphylococcus infections and the array of tuberculosis strands (Snowden, 2008). A second key factor that led to the promulgation of the eradicationist view is that by the 1960’s, rates of mortality and morbidity from infectious diseases plummeted in the US, Canada and Europe (Snowden, 2008). Credit for these declining rates was attributed to science. In actuality, however, the drop in mortality and morbidity in the US was reflective of dramatic social uplift, which included mass improvements in education, diet, wages and housing (Snowden, 2008). A third factor in the ascendance of this belief in the power of science is ethnocentrism, which in itself was reflective of historical amnesia.

The eradicationist position was inherently Eurocentric. During the time that the eradicationist view had gained popularity in the US, several authors had posited that the diseases that were being identified as disappearing from the globe were still present and continuing to wreak havoc in marginalized communities, in and outside of US borders (Snowden, 2008; Washington, 2006). The conclusion that science was conquering the world of microbes could only be based on the experiences of first world nations, in general and the communities within these nations that had access to the fruits of these scientific discoveries, in specific. It was this ethnocentric bias that led to historical amnesia. Proponents of the eradicationist paradigm ignored the fact that over the last 500 years, the West, including the US, had been punctuated by four catastrophic public health pandemics. All of these newly-emerged diseases were from
previously unknown pathogens, including Spanish influenza in 1918-1919 (Snowden, 2008). Thus, assertion of a doctrine of immanent conquest of infectious diseases rendered the US, and subsequently other parts of the world, virtually unprepared and immunologically naive.

Assured by the agreement of the leading medical authorities that the danger of infectious diseases was no longer present, the US dismantled its public health programs and brashly reduced their spending (Snowden, 2008). Simultaneously, private investment in the development of new vaccines and funding for the training of health care workers dried up. The year that President Ronald Reagan was inaugurated continued in this trend with the immediate and aggressive cut to government expenditure, including funding for the CDC (Albion Street Centre, 2012; Kull, 2010). The eradicationist position, along with right-wing approaches to social welfare policies (Quadango, 1994) informed the ongoing mass defunding of public health programs that addressed communicable diseases (Kull, 2010; Snowden, 2008). The belief that all infectious diseases were eradicable by science and the subsequent defunding of the public health programs, including the CDC, rendered the US extremely vulnerable in its response to the pathogens that cause AIDS (Snowden, 2008). However, it was high-risk social welfare policies and unequal social economic factors that continued to produce what subsequently resulted in marginalized communities becoming disproportionately infected with this virus. Marginalized communities that were (and continue to be) vulnerable to HIV include people living in poverty, Black African Americans and Latinas/os and men that have sex with men. Where administrations have sought to save money by cutting social insurance programs, communities of people of color living in poverty have paid for this deficit with their health.
Initial Cases of HIV in US

In 1981, medical doctors in the US began to witness sporadic, yet increasing unexplained cases of enlarged lymph nodes and the abnormally early onset of a very rare cancer known as Kaposi’s sarcoma. These unexplained cases were witnessed in a small number of patients in New York and California (amfAR, 2012). The symptoms were initially and formally noticed by medical practitioners among White/Euro-American relatively young adult male patients who were identified as gay or bisexual (Kull, 2010). In the summer of 1981, the CDC reported 26 cases of Kaposi’s sarcoma, all among men identified as homosexual residing in New York and California (amfAR, 2012). Initial reports in medical journals began to alert the world to this new disease that generally infected gay people and people who injected drugs (Osmond, 2010).

Initially, the virus was termed by medical professionals and journalists alike in the heterosexist and homophobic terms of “Gay-Related Immune Deficiency” and “Gay Cancer” (amfAR, 2012 p. 1).

The creation and use of these terms illustrates the assumed inherent link between homosexuality and this, at the time, new and emerging disease. Although, people who identified or were identified as homosexual were pegged as being the most susceptible to this new and alarming pathogen, there was also a prominence of a group of people that injected drugs, most of whom were poor, among the early cases of this pandemic (amfAR, 2012; Osmond, 2010). However, as June Osborn (1986) reiterates, people who used drugs were generally viewed by the media and medical professionals as already being a lost cause, unlike gay men – most of whom were White/Euro-American and middle/upper class. White/Euro-American and affluent gay men were identified by the political climate, medical profession and public opinion as redeemable and worthy of societal resources.
In 1982, this public health crisis was given a name by the CDC; AIDS (amfAR, 2012). AIDS was short for the Acquired Immune Deficiency Syndrome. In two years, the virus that causes AIDS was isolated and the US licensed a test that screened for the HIV antibody (amfAR, 2012; Osborn, 1986). By the mid 1980’s, not only was there awareness of the specific virus that causes AIDS, there was also a way to test for its antibody. This new test created a way for blood concentrates used for blood transfusions to be screened (amfAR, 2012; Osborn, 1986). Despite these scientific breakthroughs, social thought about the origins of this virus and the people that were testing positive for this virus continued (and continues to this day) to lag very far behind.

AIDS, the Reagan Administration and Communities Organizing

Anti-gay hysteria underwent a new and extremely venomous resurgence with the onset of AIDS in the US (Chirimuuta & Chirimuuta, 1987). The emergence of HIV/AIDS during the Reagan Administration entailed two very important ramifications for this public health emergency. The first consequence of the timing of this epidemic in the US was a six year time-period of silence on the part of the federal government, including then President Reagan. The backing of the Reagan Administration by social and religious conservatives and conservative political groups resulted in President Reagan not mentioning AIDS in his speeches until 1987 (Kull, 2010). The second consequence of the political climate and the timing of AIDS in the US is that gay-related AIDS organizations were barred from receiving the federal funding that had at last been appropriated to combat the spread of this infection (Kull, 2010).

It was only after 40,849 people had died from AIDS-related causes and 50,378 AIDS cases that the federal government broke its six year silence about AIDS (amfAR, 2012). It is challenging to consider this time period of “benign neglect” as anything other than egregious neglect; the planting of the seeds of the current alarming rates of HIV/AIDS in Black African
American and Latina/o communities in the US (Wallace & Wallace, 1998, p. 28). As a result of these political factors, during its onset, HIV/AIDS in the US was largely interpreted as God’s wrath on people who identified as gay, had multiple sex partners, and/or injected drugs. These monstrous conclusions maintained their popularity even as researchers warned that AIDS was an epidemic of the public health of the general population. Researchers went on to add that AIDS was transmitted by both heterosexual and homosexual intercourse and affected females more readily than males (Snowden, 2008; Chirimuuta & Chirimuuta, 1987). These warnings were offered as early as 1983 (Snowden, 2008).

Despite having been scapegoated for the existence and spread of HIV/AIDS in the US, then barred from receiving public funding for HIV/AIDS prevention, gay communities and their allies continued to organize toward a public health response that met their needs (Kull, 2010; Adam, 1997). They organized a response to HIV/AIDS that incorporated grassroots-level approaches to making information on and resources for methods of safer sex accessible. One of these methods included using language that was common in the communities where the actions towards HIV/AIDS prevention were taking place (Kull, 2010; Osborn, 1986). This response included organizing grassroots community advocacy and political action groups. The AIDS Coalition to Unleash Power (ACT UP) is an example of the AIDS activism that gay communities and their allies had organized. ACT UP’s primary mission was to bring attention to the absence of a public health response to the AIDS crisis through AIDS activism, including the slogan “Silence = Death” (Kull, 2010, p. 4). ACT UP organized and sponsored nonviolent demonstrations at locations that were identified as being critical to influencing an inclusive public health response and addressing heterosexism. These organizing strategies brought to light oppressive and inherent disparities in health-care delivery in the US for gay men, women,
Blacks, African Americans and Latinas/os (Kull, 2010). The AIDS activism that ACT UP sponsored is also credited for bringing national attention and focus to the AIDS health crisis and discrimination (Kull, 2010).

AIDS Strikes the Marginalized: From Gay Sex to a Black Disease

Throughout the 1980s and well into the 1990s, AIDS had come to be understood in the US as a disease that solely afflicted gay men and the more seldom-mentioned, injection drug users. However, the earliest confirmed case of what later came to be known as AIDS in the US was with a 16 year old Black African American male from St. Louis (Albion Street Centre, 2012; Osmond, 2010). The young man reported none of what had come to be identified as the then identified markers of susceptibility, including travel out of the country, having engaged in sex with men, having multiple/concurrent sex partners or having injected drugs intravenously (Osmond, 2010). On the few occasions that this case is mentioned, it is interpreted by historians of this epidemic as being an outlier, rather than evidence that contradicted the conclusions that gay men, people who use injection drugs, and or Haitians (amfAR, 2012) were solely susceptible to this disease.

Medical professionals and researchers have been aware that HIV/AIDS has disproportionately affected multiple marginalized populations since the earlier years of the onset of this public health crisis (Kaiser Family Foundation, 2012a; Osborn, 1986). Research findings throughout the 1980s continued to indicate that AIDS cases were disproportionately present and increasing among marginalized groups such as, people who injected drugs and communities of color, specifically Black, African American and Latina/o (Wheeler et al., 2010; Wallace, 2007; Selick, Castro & Pappaioanou, 1988). All of these communities, during the onset of this virus (and presently), were at a disproportionately greater distance from quality professional medical
care than their White/Euro-American gay adult male counterparts. However, at the time of the onset of this pandemic, people who identified as gay or engaged in sex with men were vilified in the US, regardless of their race (Washington, 2006).

Initial speculations by medical doctors stated that the cause of the syndrome was in some way connected to and concentrated on the sexual practices of homosexual men. The medical rationale that informed this speculation was a direct reflection of two value-tainted beliefs. The first, that being gay meant being promiscuous and the second that a high rate of promiscuity could potentially be harmful to the body’s immune system (Chirimuuta & Chirimuuta, 1987). This speculation is reflective of the anti-homosexual hysteria that plagued the public in the early stages of this epidemic. This anti-gay hysteria escalated into venomous assertions that gay people were sources of this disease and needed to be constrained by public health laws (Washington, 2006).

The explosive debates over the dignity and human rights of gay people that ensued took place within a racialized, gendered and class based context (Washington, 2006). These contexts impeded most of the appropriate proposed behavioral constraints from being enacted into public health law. Despite these impediments, a few places that had facilitated anonymous sex among gay men had been shut down by the health department (Washington, 2006). As a result of these debates, effective community organizing tactics and the ‘coming-out’ of a famous American actor as being gay and having AIDS, standard tactics of disease control, such as HIV name reporting, were rejected when they might have been most useful in thwarting the spread of this virus (Washington, 2006). One of the methods not used includes allocating funds to organizations that served gay communities to engage in awareness-raising during the early stages of the spread of HIV/AIDS infections. In other words, had standard tactics of disease control
been followed, instead of being mulled in explosive debates over the dignity of human rights of gay people and the unworthiness of injection drug users for medical services, the epidemic might have been controlled. Gay communities were maligned and vilified during the onset of the HIV epidemic. However, by the mid-1990s, rates of HIV/AIDS had significantly declined in these communities, except among people who were both of color and gay.

By 1997, there were several publications and news stories that informed the public that HIV/AIDS-related diseases had become one of the main causes of death among young African Americans (Washington, 2006). Publications and news journalists had gone on to further inform the public that most children living with HIV were Black, African American or Latina/o. The increasing rates of HIV/AIDS infections among Black and Latina/o communities that had been virtually ignored by media and presidential administrations since 1982 had officially been stamped as a “Black Disease” by the late 1990s (Washington, 2006, p. 332). The stamping of AIDS as a black-disease succinctly followed the Reagan, Bush Senior and Clinton Administrations’ naming of poverty as a black problem. Simultaneously, growing numbers of people receiving Temporary Assistance to Needy Families were also identified by these administrations as black dependency (Roberts, 1996; 1997). Poverty and disproportionate HIV/AIDS rates were used by political administrations to convey that Blacks and African Americans were inferior since they have been unable to pull themselves up to the ranks of the middle or upper classes.

HIV/AIDS rates within Black, African American and Latino/a communities were made sense of through the lens of the enslavement-era stereotypes of primitively animalistic sexuality. The medical profession, social work professionals and political administrations continue to focus on HIV/AIDS as primarily being a sexual disease, rather than a virus that thrives in social,
economic and political contexts of inequality. Naming the use of public assistance among Black, African American and Latina/o communities as welfare-dependency warranted punitive responses to poverty. This approach to poverty was used to validate similar responses to HIV/AIDS prevention among communities of color with the highest rates of HIV/AIDS. Funding has been and continues to be allocated towards AIDS treatment and thwarting HIV transmission in communities of color. However, the primary approach of behavioral change via the use of prophylactics renders anything that condoms do not cover as not being prioritized on the agenda of prevention. Condoms have been empirically proven to protect against HIV transmission (Wheeler & colleagues, 2010). However, they do not protect against the health needs that both predate the onset of this epidemic and have been instrumental in bringing this pandemic to these epic proportions (Washington, 2006; Roberts, 1997, Semmes, 1996).

Disproportionate HIV/AIDS rates and prevention approaches among Black, African American and Latina/o communities echoes previous public health approaches to the maintenance of well-being among these populations. For example, through-out the 1930s Blacks and African Americans with polio were largely ignored by public health campaigns for the recognition and treatment of the virus (Rogers, 2007). Most medical clinics only served White/Euro-Americans. The few medical clinics that provided services to people of color did so through segregated facilities that offered very low quality services (Rogers, 2007).

**Current Trends in Approaches to HIV/AIDS Prevention**

**The Affordable Care Act as a Structural Intervention**

Researchers agree that current approaches to reduce HIV and AIDS rates in Black, African American and Latina/o communities are in need of an increased focus on the macro-level drivers of this public health pandemic (Wheeler et al., 2010; Adimora et al., 2009;
Friedman et al., 2009a; Fullilove, 2006 & Mullings, 2005). This call to action is currently taking place within the advent of The Affordable Care Act (Medicaid, 2013). The Affordable Care Act refers to two pieces of legislation that aim to make health-care more affordable and accessible for all people living within the US borders, providing their state of residence is a participant in this federally-led program (Medicaid, 2013). These pieces of legislation are significant for a number of reasons. First, they are the closest that the US has ever come to nationalizing its health care system by imposing a limit on what insurance companies can charge their customers.

These pieces of legislation also require that everyone in every state that is participating in this federal program be insured (Medicaid, 2013). Second, The Affordable Care Act has the potential to expand health care coverage to Americans that were previously uninsured. Establishing a health-care system designed with the intention to insure more people than have ever been insured in the US’ history is sets a precedent in its young nationhood. Experts have identified being uninsured as one of the structurally-related pathways to disproportionate HIV/AIDS rates present in Black, African American and Latina/o communities (Denning & DiNeno, 2010; Kaiser Family Foundation, 2009). The passing and institutionalizing of The Affordable Care Act equates to the macro-level change of providing primary prevention (Albee, Joffe & Dusenbury, 1988) by attempting to establish access to quality medical care to more US residents than have ever before been insured.

Giami and Perrey (2012) insightfully offer that the macro-level approach of expanding health insurance coverage is taking place within the context of HIV/AIDS prevention shifting from methods of behavioral change to the advancement of biomedicalization. In this context, the term biomedicalization of HIV-prevention refers to the use of surgery and or medication in place
of altering societal-infrastructure or heightening HIV/AIDS awareness to modify sexual behavior (Giami & Perrey, 2012). Pharmacological medication is being promoted as the new effective approach to prevent the occurrence of HIV infection. Through offering a pill that can reduce HIV-risk, biomedicalization is being used to address HIV/AIDS while protecting the interests of social, economic and political status-quos and power-elites that profit from the structural-drivers and disproportionate rates of this infection.

This approach continues to use the bodies of people of color living on the margins as the market base (Rodney, 1976) for the structural repackaging of what continue to be individually-based context-striped approaches of HIV/AIDS prevention. This shift from a reliance on behavioral modification entails that a focus on condom use, increasing access to condom use and addressing environmental factors that impede on condom use will be rendered no longer necessary. Consequently, any calls for attention to primary prevention as a means of addressing this public health crisis, such as the deprivatization of the mass incarceration system (Alexander, 2010), and eradication of poverty and homelessness (Auerbach et al., 2011) will continue to be identified as unnecessary or simply not supported by empirical evidence (Green & Ruark, 2011).

Through this lens, a macro approach is being used to medicalize and maintain individual approaches that have less efficacy than condom use (Giami & Perrey, 2012) and do not address the structural-drivers of HIV/AIDS infection. This imbues the disproportionate rates of HIV/AIDS in communities of color with a greater hope of effectiveness (Giami & Perrey, 2012) while effectively maintaining the economy of oppression. Through this lens, a macro approach is being used to maintain medicalized individual approaches that have less efficacy than condom use (Giami & Perrey, 2012). The literature provides evidence to support a relationship between the macro-level factors and HIV/AIDS risk taking (Wheeler et al., 2010). However, few
quantitative studies have investigated a predisposing relationship between the structural-level factors of homelessness, incarceration and poverty with episodes of unprotected anal or vaginal intercourse among Black, African American, and Latina/o communities living in poverty.
CHAPTER IV: SOCIAL WORK, BLACK COMMUNITIES, AND HIV AND AIDS

The History of the Social Work Profession and its Concern for Black Citizenship in the US

This chapter discusses the relationship between formation of the social work profession and ongoing efforts of Blacks, African Americans and Latinas/os to secure the basic entitlements of citizenship to the United States. A trajectory of the history of social work is offered, with a special attention to the approaches and work of Black social workers. The practice, agency, community and societal contexts of social work and HIV/AIDS are discussed and current approaches to the prevention of this infection are outlined.

The trajectory of concern within the social work field for the disproportionate rates of HIV/AIDS among communities of color mirrors the relationship between the profession and the on-going struggle for Black Citizenship in the US. Blacks and African Americans were granted citizenship status in 1866 through the 14th Amendment (Lee, 2010). However, these communities continue to be barred from the necessities and entitlements of full citizenship status, including adequate health care and non-stigmatizing social welfare programs (Dattel, 2009; Roberts, 1996; DuBois, 1935). Similarly, access to citizenship status has frequently been used by social welfare policies to increase, curtail, medicalize and criminalize immigration among Latina/o communities (Molina, 2006; 2011; Hajat et al., 2000, Roberts, 1996).

Since the onset of the social work profession, the role of social work professionals through working as guides for social, economic and political well-being, has been to equip individuals, families and communities for citizenry (Wilensky & Lebeaux, 1965). The work, ideals and professional affiliations that this social work role has translated into have inextricably taken shape within the context of White ideals of nationhood in service to an exploitive market based society (Wilder, 2000; Roberts, 1996). These ideals of US national identity have
continued to be core tenets of the forming and on-going professionalizing of social work (Kennedy, 2008).

Anti-Slavery and Anti-Black: Early Social Work Pioneers and Social Motherhood

Working to protect individuals, families and communities from the hazards of industrialization served as a platform for White/Euro-American women to renegotiate their role in 19th century US society. Early social work pioneers effectively advocated that working to maintain social order by ameliorating social problems was a form of community motherhood (Harkavy & Puckett, 1994; Wencour & Reisch, 1989). Social or Community motherhood refers to working to maintain social order as being an extension of woman’s work outside of the home (Harkavy & Puckett, 1994). Settlement houses and charity organization societies provided a socially acceptable and at times, profitable professional outlet for a labor force that was predominantly comprised of college-educated White/Euro-American women (Wencour & Reisch, 1989). However, persuading public opinion, financial sponsors and white Euro-American male gatekeepers of the professional status of social work meant underscoring the race and gender accords of the political climate.

Advocacy and activism for European and White/Euro-American women to have more sanitary working conditions, access to higher education and opportunities for careers outside of the home was born out of their work in the abolitionist movement in the 1830s (Davis, 1983). Angela Davis (1983) explains that White/Euro-American housewives and “mill girls” experienced their respective oppressions as a shared lot with enslaved Blacks and African Americans (p. 33). White/Euro-American women were actively drawn into the abolitionist movement and the movement for women’s suffrage simultaneously (Davis, 1983). Reflective of the ideals of the abolitionist movement and despite the success of the Freedman’s Bureau
(Dubois, 1935), by 1870, political administrations, followed by public opinion, had determined that Blacks and African Americans were incapable of being assimilated into US nationhood (Dattel, 2009). One-hundred and forty-five years later, Blacks, African Americans, andLatinas/os remain on the outskirts of US society as disproportionately incarcerated, living in close to poverty and inordinately diagnosed with HIV/AIDS.

Dattel (2009) explains that Whites/Euro-Americans who were in defense of slavery believed that African Americans were biologically inferior to Whites. Similarly, abolitionists believed that slavery had irreparably damaged the ability of Blacks and African Americans to effectively participate in the nation’s citizenry (Dattel, 2009). Dattel (2009) reiterates Genovese’s (1969) earlier research findings that anti-slavery had gone hand in hand with anti-black. While Blacks and African Americans had continued to be locked by institutionalized and overt racism into continuing to mine cotton, the nation’s most important export (Dattel, 2009), the large scale immigration of Europeans replaced women and children in factory work in the North (Wilensky & Lebeaux, 1965). Cities were not growing fast enough to accommodate the rapid urbanization of previously rural communities. Factory work and community life took place in squalid conditions (Wilensky & Lebeaux, 1965).

Industrialization in the context of free-market goals brought with it an intense social upheaval that highlighted a need for a change in social, economic and political infrastructure (Molina, 2006; Wilensky & Lebeaux, 1965). However, politicians and stakeholders identified cultural differences among newly arrived European immigrants and as the social problem and cause of the foul living conditions of city life (Berson, 2004). By the advent of the settlement movement in 1890, social welfare services were only accessible to abandoned White/Euro-American women (Roberts, 1996) and European immigrant communities (Wilensky & Lebeaux,
1965). The roots of the social work profession took shape as the voice of middle/upper class White/Euro-American women to prepare White/Euro-American and European immigrant communities for citizenry, while inherently and directly participating in the denial of full citizenship status to Blacks and African Americans. It is important to note that even in the context of supporting an anti-Black hierarchy of belonging, social work with low-income mothers and newly arrived immigrants took the form of social control, moral policing and an Americanizing ethnocentrism. White/Euro-Americans living in poverty and European immigrants were treated as deserving of public support, yet, in need of being reformed, bettered and educated.

**Jane Addams and Mary Richmond: Social Workers of the Same Struggle**

In the latter half of the 19th century, organizing the distribution of charity and adapting European immigrants to American cultural norms through settlement houses coexisted together. Both approaches to social work epitomized key themes of the Progressive Era: social reform and social uplift (Wencour & Reisch, 1989). Jane Addams believed that research, residence and immersion in the communities of the people she and her staff acculturated would alleviate poverty (Berson, 2004). Addams’ community-based approaches to making sense of poverty and its causes predate the first university sociology courses in the US (Harkavy & Puckett, 1994). Jane Addams and the University of Chicago worked hand in hand in engaging in social research and ensuring its direct use for the benefit of European immigrant communities (Harkavy & Puckett, 1994). Simultaneously, the Scientific Charity Movement among charity organization societies was quickly gaining in popularity and prominence in the US (Waugh, 2001).

Charity organization societies worked to blend pre-industrial revolution alms-giving with new scientific methods of the progressive ideals of social uplift and philanthropy (Waugh, 2001).
Settlement house supporters and charity organization society sponsors were in agreement that the industrial economy created immense wealth and simultaneously produced vast poverty. Charity organizations answered this dilemma by encouraging members of prosperous upper classes to sympathize with the harsh realities of the poor by financing solutions to poverty (Waugh, 2001). However, while the settlement movement sought to Americanize European immigrants, charity organization societies used punitive approaches to reduce poverty (Waugh, 2001). Both early social work approaches to addressing social problems enforced the belief that the reform of the individual was pertinent to enabling her/him to become an independent and productive member of US citizenry. Despite the differences in these approaches to community well-being, both settlement and charity organization workers utilized what they had identified as scientific methodological approaches to social service delivery and poverty reduction, from their respective positions (Wencour & Reisch, 1989; Wilensky & Lebeaux, 1965).

Settlement houses and charity organization societies modeled their approaches after the prevailing features of corporate management. These features included investigation, organizational structure and curtailing any superfluous spending to solve the problems of poverty (Wencour & Reisch, 1989). The notion of “scientific charity” had advocated doling out all charitable relief in a businesslike, scientific and efficient manner as a means of alleviating the lot of the poor (Wencour & Reisch, 1989, p 31). Modeling corporate structure fortified negatively prejudiced attitudes about the behaviors of poor people that had already informed social service policy and delivery. Implementing these changes included restricting access to services and support, while eliminating any input from the social work client in determining the goals of service outcomes (Wencour & Reisch, 1989). Jane Addams worked with the University of Chicago to institutionalize social activism en-route to social reform (Harkawy & Puckett, 1994),
while at the same time, Mary Richmond marketed this new approach to corporate sponsors of charity organization societies (Wencour & Reisch, 1989). These approaches later evolved into the “casework” method of social work (Wencour & Reisch, 1989, p. 97), which continues to be the primary commodity of social work services.

At the close of the Progressive Era and following WWI, the political climate had shifted into a more rigid focus on adapting the individual to the greater society. Harkavy and Puckett (1994) explain that by 1920, universities of higher learning had fully distanced themselves from social reform. Natural science and scientific rigor circumscribed the focus on the social problems of city living (Harkavy & Puckett, 1994). Empirical science was no longer deemed compatible with social action, social justice or direct democracy. Eugenic ideas that had taken shape in the 1800s had gained greater corporate sponsorship and state-level legislative support in the US at the turn of the century. In the early 1920s, medical approaches to achieving social unity were now considered to be the cutting edge of social reform. Angie C. Kennedy (2008) adds that Addams’ and Richmond’s structural approaches entailed the active support for forced sterilization and or permanent institutionalization for communities that were identified by themselves and their financial sponsors as incapable of assimilation. These communities included Blacks, African Americans, Latinas and low-income, White/Euro-American women (Kennedy, 2008; Washington, 2006).

Sterilization and/or permanent institutionalization served as solid common ground between Addams’ settlement house approach and Mary Richmond's social diagnosis approach to social problems (Kennedy, 2008). The narrative that the settlement movement utilized a structural approach to social problems, while charity organization societies employed a micro-level approach to remedying pauperism is flawed. Both approaches to social work practice
worked to fuse structural approaches with micro-level service distribution, albeit, it their own ways. In addition, both approaches shared the common ground of underscoring Blacks and African Americans as unworthy of the entitlements of full US citizenship, including child bearing (Kennedy, 2008; Roberts, 1996; 1997). By 1920, public service was left for public agencies while social work professionals generally moved into working in private agencies with middle/upper class communities (Harkavy & Puckett, 1994; Wilensky, 1965).

Mary Richmond’s response to Flexner’s (1915) question helped social workers to shape their professional identities and exert their expertise by embracing scientific practice methods (Harkavy & Puckett, 1994; Wencour & Reisch, 1989). These methods included an emphasis on detailed case records, scientific nomenclature, social diagnosis and an exhaustive investigation. Casework had become social work’s main service commodity in its use of psychoanalytic approaches to helping individuals to adapt to their surroundings (Wencour & Reisch, 1989). The shift moved social workers and the social work profession even farther from its focus on social change, social uplift and social justice. By 1929, preparation for settlement or community-level work was absent from professional social work training programs (Harkavy & Puckett, 1994).

The Legacy of Progressive Era (1890-1920) Social Work

The Progressive Era (1890-1920) refers to a time when the economic and social problems that industrialization in a capitalist context had introduced to the US were believed to be most effectively addressed by providing quality education to children, a safe environment for communities and safe workplace for workers (The Eleanor Roosevelt Papers Project, 2015). Early progressives, like Jane Addams, believed that government could be a tool for change in ameliorating the social and economic problems that society faced. Dorothy E. Roberts (1996) insightfully explains that Progressive Era (1890-1920) social work was effective in
accomplishing two significant outcomes. First, the campaigning of women like Jane Addams and Mary Richmond during achieved the remarkable feat of changing the understanding of public welfare and single motherhood (Roberts, 1996). With advocating for mother’s aid programs, these women called for prevailing laissez-faire approaches to social welfare and poverty to be recast. The activist work of Progressive Era women also aimed to remove public assistance from the stigma of earlier forms of social alms-giving (Roberts, 1996). Through the work of women reformers, public opinion and federal sponsorship had been convinced that single motherhood was an urgent social problem that would most effectively be addressed through institutionalized social welfare programs (Roberts, 1996).

As a result, federal-level aid was provided to female survivors of misfortune and male irresponsibility (Gordon, 1994). However, advocacy for single motherhood as deserving of support alienated everyone living in poverty who was not a White/Euro-American woman or a child. The worthy poor were exclusively identified as women and children. More progressive and universalist approaches to social support that included men, Blacks, Latinas/os and adults were also being advocated at that time, but were defeated in favor of more excluding legislature (Gordon, 1994). The second significant outcome of Progressive Era social work is that by supporting the excluding approaches to social welfare in place of more progressive and universalist proposals, the profession underscored enforced gender, class, ability and race-based segregation. Gordon (1994) and Roberts (1996) attribute women’s advocacy for maternalist legislation during the Progressive Era as the origin of social welfare’s stratified structure.
Black Social Workers

Despite its roots in the abolition movement, as a profession, social work, did not provide services to Black and African American communities until the Civil Rights movement in 1964. It is imperative to note that Blacks and African Americans did not wait for the profession to take an interest in their struggles in order to help themselves (Carlton-LaNey, 1999; 2001). Carlton-LaNey (1999) illustrates that during the Progressive Era, African American social workers were concerned with the individual-level challenges that Blacks were facing, while also working to address larger societal issues, such as racism. For Black social workers, effective practice entailed both a micro and macro orientation (Carlton-LaNey, 1999).

Black social workers worked tirelessly to start settlement homes, open schools, provide classes, create the option for repatriation to African nation-states, engage in social activism against lynching and distribute public assistance among African American communities (Carlton-LaNey, 2001). E. Franklin Frazier, an African American sociologist turned social work practitioner, worked to establish and accredit the first African American school of social work (Chandler, 2001). Carlton-LaNey (2001) explains that Black and African American social workers designed their intervention to access planned change in communities and community-level institutions while working to locate, develop, link with and harness community resources.

The Civil Rights Movement and the Social Work Profession

Wilensky and Lebeaux (1965) identify that for the social work profession, social issues are opportunities for service and or branching out into a new client base. During the Civil Rights Movement of the 1960s, the Kennedy, then the Johnson Administrations had increased funds for community development through housing assistance, equal opportunity employment, public assistance and communities organizing (Roberts, 1996). Low-income communities were now
served as new markets for social work services, especially since these contracts included a community clause that mandated the involvement of community members. Social workers worked as service brokers and community supports. Unlike the Settlement Movement of the 1860s, the social work profession did not have the same influence in federal or state level conversations regarding social welfare funding and program design. Less access to these federal and state level conversations was a direct result of the profession’s move into private practice and out of communities living on and closest to the margins of US society. This shift affected the field in two key ways.

First, since the social work profession had wielded less political pressure than in prior administrations, they had very little influence in the design of the funded programs. Secondly, social workers working in low income Black, African American and Latina/o communities were largely funded through Civil Rights-based grants and programs. When a majority of the Civil Rights legislation was defunded by 1972, so were most of the federally-funded contracts that social workers had acquired. Social workers responded to being out of the job market by leaving Black and African Americans communities, and returning to fee-for-service work and private practice in middle and upper class enclaves (Specht & Courtney, 1994). Social workers re-entered into private practice while social welfare was shifting from social insurance to punitively executed public support (Roberts, 1996).

When Blacks, African Americans and Latinas/os had attained access to social welfare support, public assistance served as a tool of institutionalizing social control over and legislating the behaviors and the lives of the disproportionately Black and Latina/o poor (Roberts, 1996; 1997). When the funding dried up, the social work profession and social work practitioners distanced themselves from working with low-income communities of color at a time when these
communities might have benefitted most from the support of the profession. Despite the flight of
the profession from communities of color, individual social work practitioners continued to serve
Black and African American communities, such as Dr. Elaine Pinderhughes (Pinderhughes,
1983), Dorothy I. Height (Evens, 2010), Whitney M. Young (Jet, 1961) and many other Black
social workers. On May 8th, 1968, a group of Black social workers attending the National
Conference on Social Welfare walked out of this meeting and formed what became the National
Association of Black Social Workers (NABSW, 2015). Dr. Shirley Better, Lenny Barry, Joan
Coleman, and their peers recognized the ongoing social injustices that communities of color
continued to experience despite the achievements of the Civil Rights Acts and the Great Society
programs (NABSW, 2015).

The NABSW has become the foremost advocacy group that was established by social
workers to address social inequities and concerns of Black communities throughout the United
States (NABSW, 2015). Hanson (2014) explains that the formation of the National Association
of Social Workers (NASW) was a reflection of a need among social work practitioners for
greater unity within the social work profession. Practitioners had also expressed desire for an
organizational structure where resources for social workers could flow more freely through and
be utilized more effectively for supporting social welfare programs (Hanson, 2014). Despite the
formation of NASW speaking to these needs, providing social work services to Blacks, African
Americans or Latina/o communities living in/close to poverty was not placed at the center of
these efforts. The formation of the NABSW addresses this gap in services and was formed to
support communities of color to receive all of the entitlements that citizenship entails (Reid-
Merritt, 2010).
Roberts (1996) accurately describes that at its foundation, federal/state-level aid provides citizens with the necessary prerequisites to fully participate in the social life of the community and the political-decision making of the nation. A minimum sense of dignity, well-being and security are necessary for people to fulfill the responsibilities that citizenship entails (Gordon, 1994). Thus, social welfare in all of its forms is both a badge of membership in the US national community and a basic necessity to fully participate in this membership (Roberts, 1996). Blacks, African Americans and Latinas/os have historically been barred from the entitlements of US citizenship. Despite the profession’s work to serve as a force for social justice, acquiescing to oppressive ideals of US nationhood continue to undermine social work’s potential to actualize this long-held value, especially in regard to achieving the full citizenship of Blacks and African Americans (Roberts, 1996). Radical social work, and more recently, critical theory social work seek to remedy the profession’s gap in working for social justice in marginalized communities. However, these approaches either do not mention the role of race in social justice or address race as one of multiple oppressive identities that take root in structural-level injustice.

**Radical Social Work**

De Maria (1992) defines *radical social work* as theorizing and practicing social work with a philosophical leaning toward the importance of discovering the primary causes of oppression, while transforming the insights gained from individual-level experiences into direct social action that challenges macro-level structures. Moving from structural analysis to structural practice is a core tenet of radical social work practice (Reisch & Andrews, 2001). Radical social work pulls on a class analysis as it strives to reduce poverty by addressing economic injustice and develop radical social work approaches (Feguson, 2007; Reisch & Andrews, 2001). Radical social workers work to promote radical ideas and practice techniques
by providing forums for developing critical awareness of social issues, clarifying views, sharing experiences and discussing current events (Bailey & Brake, 1975). Several authors identify a diversity in radical positions in social work theory and practice (Reisch & Andrews, 2001).

Jansson (1994) asserts that although all radical social workers may be share the common ground of focusing on macro-level structures as producing micro-level deficits, some may work to establish redistributive tax programs, while others may work to transform capitalist institutions into publically run industries. Critical social work theory, feminist social work and structural social work have their roots in radical social work (Ferguson, 2007). All of the sub-theories of radical social work theory are united in their focus on transforming power-relations at every level of social work practice (Ferguson, 2007). In its formation, radical social work theory centered class based oppression. Contemporary radical social work theory has expanded to include that all forms of oppression need to be eradicated. Radical social work existed as organized approaches to addressing the social problems that individuals faced from the mid-1930s to the present (Ferguson, 2007; Reisch & Andrews, 2001).

Reisch and Andrews (2001) explain that only a few radical social workers and no radical movements existed prior to the New Deal. Radical social work practice continues to draw support from social work students, community level practitioners, world renowned academics and researchers, however, it has never been the primary approach of the social work profession in the US (Ferguson, 2007; Reisch & Andrews, 2001). Jane Addams is frequently identified by radical social work theorists as one of the earliest social work radical practitioners of the field because of her focus on cross-class connections, policy level change and the necessity of cultural expression classes at Hull House (Ferguson, 2007; Reisch & Andrews, 2001). In this lens, Addams’ Hull House policies of prohibiting service to Blacks, African Americans, Latinas/os
and Indigenous/First Nation Peoples (Ferguson, 2007) and her staunch support for forced sterilization of members of these communities (Roberts, 1996) are seen as congruent to her radical social work approaches. Interpreting Addams’ work as demonstrating radical social work practice illustrates two key flaws within radical/critical social work theory and serving Black, African American and Latina/o communities.

At its formation, radical social work was largely influenced by Marxism. It centered class based oppression without any focus on race or the constructs of Whiteness. This trend is still present in the more recent theories that have grown out of radical social work theory, such as critical social work theory and structural social work theory (Ferguson, 2007; Healy, 2005). Similarly, more recent off-shoots of this theory center all oppressions without a clear and focused approach to race and racism. In this approach, race is interpreted as though it is one of many, despite its unique history or its on-going maintenance in the US. Simultaneously, lumping race together with all forms of oppression does not address the gap in social work services that was created by the profession historically and specifically excluding Blacks, African Americans and Latinas/os from social work caseloads. Current directions in critical social work theory include a post-modernist approach to mapping the location of individual level identity in working to challenge and change macro-level structures (Ferguson, 2007). Race is depicted as one of several identities that has been created by imperialist, macro-level structures. Race-based identities, like gender-based identities and able-body based identities must be done away with in order to embrace the belief that all people belong to one race/group: the human race (Ferguson, 2007).

In its unaltered form, radical social work and its contemporary off-shoots mirror the 1980s cartoons: The Flintstones and The Jetsons, with people of color depicted as non-existent in
the past and in the future. Finally, radical social work does not address the inherent conundrum of getting paid for social change in the context of a capitalist/market based society. My suggestion remains for social work to organize itself to develop the needed resources to engage in this work so social work can fund, finance and maintain itself. Without deliberately centering Black, African American and Latina/o communities, and working out the contradiction of what becomes fee for social change services, radical social work continues in the same tradition of the social work profession of falling short of supporting the social justice that we, as social workers, are passionate about.

Radical/critical theory social work has made significant contributions to the social work field and to social workers in numerous ways. First, like previous and current prominent practitioners of the field, radical social work are a deliberate call to consciousness for all social workers. Freire (2000), and Pinderhughes (1983) highlight the importance of coming to consciousness in the work to create a new society and be allies to people creating a new society. Second, radical social work theorists call on social workers to be deliberately active in working with communities living on the margins to achieve the social change that they envision. Finally, these theories support creating spaces for critical conversations and dialogues about oppression.

Social Work Contexts of HIV and AIDS

The social work profession became involved in working with communities living with HIV or AIDS through the work of individual social work professionals, as opposed to a mandated call from the profession. Alan Rice, Diana Rowan (Rowan & Rice, 2013), and Gary Bailey (Bailey, 2012) explain that like many of their peers, they were called into working with clients with HIV or AIDS either through having experienced the effects of HIV infection in a close personal relationship or as a professional opportunity. For Bailey (2012), after having lost
three friends to AIDS by 1987, he knew that he had to do something more than what he had already been doing. As a response, Bailey (2012) became a part of the AIDS Action Committee, located in Boston. In 2005, Bailey (2012) was a part of policy change in his home state of Massachusetts that legalized the purchase of syringe needles without a prescription, thereby promoting the use of clean needles among injection drug users and preventing HIV infection through shared and/or dirty syringes and needles.

Rice (Rowan & Rice, 2013) shares that he started in HIV/AIDS work in 1983 when he accepted a position as a medical social worker. Rice (Rowan & Rice, 2013) explains that he later learned that the hospital unit where he was working had gone through several medical social workers before him. For Rice (Rowan & Rice, 2013), this further illustrated that few, if any social workers wanted to work with AIDS patients. Bailey (2012) and Rice (Rowan & Rice, 2013) illustrate the courage that social work practitioners have in their work when they are moved by a sense of personal responsibility and/or professional accountability. What their stories also illustrate is that the social work profession did not issue a formalized mandate or call to action for social workers to serve clients or communities living with HIV or AIDS until later on in the epidemic.

The Social Work Practice Context of HIV and AIDS

In an interview with Diana Rowan, Alan Rice describes his position as a medical social worker consisting primarily of discharge and counseling (Rowan & Rice, 2013). Hadden (personal communication, April 8, 2014) shared a similar sentiment about her work as an MSW student intern at Harlem Hospital in 1989, where she was assigned to the Infectious Diseases Unit to provide counseling and discharge services for persons with AIDS. Rice shares further, that from the start of his tenure in his role as medical social worker in 1983 to 1987, most of the
patients who were dying of AIDS did not live long enough to be discharged from the hospital. Rice worked diligently to get housekeeping to come in and regularly clean the rooms of patients with AIDS (Rowan & Rice, 2013). Rice also had to make sure that meals were delivered into the room of his clients rather than being piled up outside their rooms (Rowan & Rice, 2013). In addition, Rice facilitated support groups for people with AIDS and kept them up to date on when new medication clinical trials that were taking place (Rowan & Rice, 2013). Rice had up to 100 patients at one time. His experiences with the clients that he worked with illustrated to Rice (Rowan & Rice, 2013) that many of the people he had served who were dying of AIDS really wanted someone to sit and talk to them for more than a few seconds and closer than from a two to three feet distance.

In the interview, Rice shares that people living with HIV or dying of AIDS seeking care at his unit were very disenfranchised. Rice explains that they were of lower income, had challenges obtaining insurance coverage for care, were experiencing family issues and working through substance abuse all at the same time (Rowan & Rice, 2013). When Rice first started out, his client-load consisted predominantly of White/Euro-American gay men. Rice observes that the more HIV and AIDS began to shift in the public discourse into being known as a “Black disease”, funding for care dried up, despite Black and African American patients still having all or more of the listed challenges than their White gay peers (Rowan & Rice, 2013; Washington, 2006, p. 53). Rice and Rowan explain that unlike in 1983, currently, antiretroviral medication exists, housing and financial benefits are available and HIV and AIDS are considered chronic illnesses as opposed to a deadly diagnosis (Rowan, 2013; Rowan & Rice, 2013) as it was in the past. As it seems, Rice and Rowan may be overlooking the disproportionate rates of HIV/AIDS
in Black, African American and Latina/o communities, including the history of poor health outcomes of these communities in the US.

Rice’s professional experience has shown him the importance in asking about sexual history in the biopsychosocial interview as a means of assessing the HIV risk in the client’s life (Rowan & Rice, 2013). Rice and Rowan share that using the ecological model as a means of addressing the barriers that are in the way of the well-being of people living with HIV or AIDS has been an asset in their work (Rowan & Rice, 2013; Rowan, 2013). Social work practitioners working with people living with AIDS early in the epidemic served in the capacity of providing psychosocial support, counseling and helping families with grief and loss (Rowan & Rice, 2013). More recently, Rice has been working with people that have been diagnosed with HIV, but are denied insurance coverage for medical care because the number of HIV anti-bodies in their blood are not high enough to qualify for the revised definition of HIV (Rowan & Rice, 2013).

Other social workers such as Dr. Bernadette Hadden and Dr. Willie Tolliver became engaged in HIV/AIDS work through research, as well during the early 1990s by providing sex-risk behavioral HIV prevention interventions to Methadone Maintenance Program participants (Schilling, El-Bassel, Hadden & Gilbert, 1995). With the advent of antiretroviral medications in 1996, the medical field took the lead on HIV/AIDS care and research. Social workers were and continue to be seen as service providers in support of the physician. Rice explains that in the practice context of social work with people living with HIV or AIDS, the primary task is to represent the ego of the patient (Rowan & Rice, 2013). Reflective of this trend, the Ryan White Act shifted funds to medical case management from psychosocial services (Rowan, 2013). Rowan (2013) explains that social workers followed the funding. Social work practitioners who
continued to serve communities of color living with HIV or AIDS had to be adept at finding creative ways to bill for both psychosocial and concrete needs of the clients that they served.

The Social Work Agency Context of HIV and AIDS

At the time that Rice was interviewed, he shared the insight that the funding provided by the Ryan White Act would likely be combined or restructured into a different type of funding source (Rowan & Rice, 2013). This shift can serve as an opportunity for more social workers and social work agencies to get involved in HIV and AIDS prevention. There are many chronic diseases that afflict social work clients, even though HIV and AIDS are very different from the rest. Social and community-based programs are expensive to run (Rowan & Rice, 2013). Rice shares that his concern is that the way in which social workers frame the problem that they are seeking funding to remedy will need to change, rather than the funding itself disappearing (Rowan & Rice, 2013). According to Rice, programs that serve social work clients must create ways to sustain themselves (Rowan & Rice, 2013). If social workers can show the host agency that the program is self-sustaining, the program will not be dismantled or absorbed into the agency (Rowan & Rice, 2013).

The Community Context of Social Work, and HIV and AIDS

Several social work scholars revere the community as a place of potential support, advocacy, organizing and activism. Wheeler (2007) identifies that social work community-level practice in the onset of AIDS in comparison to the advent of antiretroviral medication has been drastically different. Wheeler (2007) reflects that in the early to mid-1980s, social workers chained themselves to state and federal buildings demanding funding for services in the communities most devastated by AIDS. Calls for social justice and health care equity rang throughout the streets (Wheeler, 2007). Now, rapid testing sites exist where hospitals used to be
filled with people dying (Wheeler, 2007). Wheeler (2007) explains that micro-level arsenals are essential in working to thwart and eradicate HIV and AIDS. However, since the advent of antiretroviral medications, social workers have again joined medical personnel in moving away from addressing the economic, political and social structures that predispose some communities’ proximity to HIV or AIDS over others.

Weiss, Dwonch-Schoen, Howard-Barr and Panella (2010) similarly illustrate that community members can be a force in recognizing and addressing disproportionate HIV/AIDS rates in their area. Weiss and colleagues (2010) worked with a community located in a county in south Florida to address what they had identified as the problem of high HIV rates. Community members conducted a phone survey of over 1,000 residents to assess what their neighbors identified as the problems facing the county and what change they wanted to see (Weiss et al., 2010). The community members learned that their neighbors were ready for a change, too. The community members formed an HIV committee which worked with a local high school to incorporate more comprehensive sex education for students (Weiss et al., 2010). The committee also used available resources to distribute a locally produced DVD about methods of HIV prevention. Weiss and colleagues (2010) underscore the need for social work professionals to work in community level capacities as a means of supporting the self-determination of communities to address what they name as the problems that plague them.

Wheeler (2007) adds to the work of Weiss and colleagues (2010) by calling social work professionals to action in communities that have and continue to be hardest hit by the epidemic. The role of social workers in the increasingly medicalizing landscape of HIV/AIDS prevention is to move state-of-the-art social and behavioral interventions into practice in ways that are applicable for Black, African American and Latina/o communities. Social workers must
simultaneously be involved in informing how existing interventions can be more effectively adapted to these communities en-route to the development of new interventions (Wheeler, 2007). In addition to these skills, professional social workers cannot lose sight of the ways in which structural-factors create the contexts in which disproportionate rates of HIV and AIDS in communities of color fester (Wheeler, 2007). It is ineffective for HIV/AIDS work to begin and end with the individual client when the evidence overwhelmingly points to the roots of the disproportionate rates of this infection as a consequence of social, economic and political injustices that continue to shape micro-level options (Wheeler, 2007).

**The Societal Context of Social Work, and HIV and AIDS**

Rowan (2013) offers that in the US, HIV and AIDS are no longer considered to be social problems or public health pandemics since they can be successfully treated by medical attention. According to Rowan (2013) antiretroviral medication has led to apathy among young adults that informs them to not use protection during sexual intercourse and a form of fatalism among Black and African American men that have sex with men. Rowen (2013) pontificates that this sense of fatalism among Black men that have sex with men has its roots in feelings of shame and poor self-image. Rowen (2013) offers that this sense of fatalism among Black men can be remedied by culturally tailored education and counseling, which social workers are very skilled in doing. Rowan (2013) is clear that Black men that have sex with men are disproportionately affected by HIV and AIDS, however, her intervention is aimed more at fixing an individual presumed to be broken rather than to address a macro-system already understood to be oppressive.

Antiretroviral medication is continuing to be used to medicalize HIV/AIDS and attention is being shifted way from remedying poverty, inequality, stigma or the privatization of the punishment industry – all of which contribute to the disproportionate rates of HIV and AIDS
among communities of color. HIV and AIDS transmission still carries the stereotype of only infecting people with bad or socially abnormal behaviors (Rowan, 2013). The societal context of HIV and AIDS is ignored, and the more that social workers primarily focus on individual-level interventions, the more the stigma is strengthened. Although social work authors mention that communities of color continue to be disproportionately affected by HIV/AIDS, they still suggest the use of micro-level interventions that do not address macro-level factors such as lack of housing, stigma, unemployment, homelessness or disproportionate incarceration. Limiting the social work response to individual-level factors simultaneously limits the reach of the ecological approach. Wheeler et al (2010) advocate that macro-level policy change is instrumental in the process of positive social change for the well-being of marginalized and oppressed communities. Despite social work’s foundation in organizing, research and direct practice, the efforts of social work professionals remain entrenched in individually-rooted approaches of HIV treatment and prevention (Rowan, 2013; Bailey, 2012; Wheeler et al., 2010).
CHAPTER V: REVIEW OF THE EMPIRICAL LITERATURE

This chapter presents an in-depth review of the literature of HIV/AIDS among communities of color in the US. This literature review has been organized by year of publication and theme. Therefore, the themes of HIV/AIDS among Black, African American, and Latina/o communities are discussed in the order of the earliest publication to present.

Empirical Research Findings

Need for Macro-Level Interventions as a Method of HIV/AIDS Prevention

There are several empirical study findings that are relevant to the proposed research. In 2007, Hallfors and colleagues (2007) published their findings from a quantitative study that examined micro-level drug and sexual behavior patterns. Hallfors and colleagues (2007) were interested in investigating if racial disparities in STDs and HIV prevalence could be accounted for by individuals’ behavior patterns regarding drug and sexual practices. The researchers extracted the data from the National Longitudinal Study of Adolescent Health (Hallfors et al., 2007). Study analyses were limited to non-Hispanic Black and White respondents between 18 and 26 years of age (Hallfors et al., 2007). Bivariate and logistic regression analyses were used to examine STD/HIV prevalence before and after controlling for covariates (Hallfors et al., 2007).

Findings of this study indicate that when engaging in high risk behaviors, White young adults in the US are at elevated risk for STDs and HIV (Hallfors et al., 2007). However, even when behaviors include HIV risk prevention, Black young adults in the US are at high risk for STD or HIV contraction (Hallfors et al., 2007). The authors conclude that factors other than risk behavior appear to account for racial disparities in HIV and STD rates among non-Hispanic Blacks and Whites in the US (Hallfors et al., 2007). Hallfors and colleagues (2007) identify the
need for population-level interventions, including greater research into how macro-level factors inform micro-level rates of STD and HIV prevalence within Black communities. Findings from Arp III’s (2004) research suggest similar conclusions.

As mentioned, Arp III (2004) presented his findings from a research project that reviewed the prevention strategies of three health-related agencies. These three health agencies operated within three Black communities in Baton Rouge, Louisiana. The three Black communities had the seventh highest number of AIDS cases of any urban city in the US during the time of the study (Arp III, 2004). All three of the agencies were under contract with the State of Louisiana HIV/AIDS program and funded to reduce the rate of HIV transmission in East Baton Rouge (Arp III, 2004). According to the findings from this study, all of the agencies reported surpassing their goals of information distribution, condom availability, street outreach, peer-led programs and counseling and testing sessions (Arp III, 2004). Findings also identified that despite these successes, the strategies implemented failed to reduce the increase of HIV/AIDS infections in these three Black communities (Arp III, 2004). Arp III (2004) proposes that State HIV/AIDS prevention policy allocate adequate funds and resources to address salient issues in these communities that mediate prevention methods. These issues include addressing drug use, cyclical incarceration and unsafe environments for sexual identity, particularly homosexuality (Arp III, 2004).

Research on the Relationship between the Macro-Level Factors and Micro-Level Behaviors

In 2006, Friedman and colleagues (2006) sought to explore associations between policing policies of people that use injection drugs and HIV seroprevalence. Friedman and colleagues (2006) utilized cross-sectional analysis of data to estimate the number of people that use injection drugs in 89 metropolitan areas in the US. These areas were then regressed into three
measures according to number of corrections expenditures, drug arrests and police employees per capita (Friedman et al., 2006). Findings from this study suggest that high rates of the three measures of “legal repressiveness” are associated with higher HIV rates among people that inject drugs (Friedman et al., 2006 p 97). The researchers identify that more studies are needed to determine if the associations illustrated are causal. However, Friedman and colleagues (2006) surmise that legal repressiveness may incur the highest cost of HIV among people that inject drugs, while having very little effect on deterring injection drug use. Similarly, Blenenko, Shedlin and Chaple’s (2005) findings offer comparable insights.

In 2005, Belenko and colleagues (2005) published findings from a qualitative study that interviewed 300 incarcerated New York City individuals. Data from these interviews were derived from structured interviews with samples of people that were under one of three types of criminal justice supervision (Belenko et al., 2005). The final study sample comprised 300 interviewees; 100 incarcerated people from prison, 100 people on probation and 100 people on parole (Belenko et al., 2005). The authors identify that no clear patterns of risk behavior by race emerged in the data, despite the relatively high HIV rates among African American study respondents (Belenko et al., 2005). Findings from this study illustrate that knowledge level of HIV is high among the respondents. Study participants reported that there is inconsistent access to HIV prevention services and education within correction settings (Belenko et al., 2005). Belenko and colleagues (2005) suggest that community-level interventions be expanded for people on probation and parole. In addition, they recommended that harm-reduction approaches and culturally appropriate HIV education be made mandatory within correctional settings (Belenko et al., 2005).
Macro-Focused Intervention Research and HIV/AIDS Prevention

In 2011, Monica Melton published her findings from a qualitative study. Melton’s (2011) study sought to access and investigate the perspectives of Black women living with HIV seropositive status. Melton (2011) identifies that the perspectives of these women as voiced by these women remains largely understudied in the literature of HIV prevention among Black and African American communities. Melton (2011) accessed a sample size of 30 Black women with seropositive status in a Florida inner city. Using semi-structured one-on-one interviews, Melton (2011) asked women about their perspectives of HIV prevention. Women interviewed indicated that stigmas were interconnected and informed their sex behavior decisions, in addition to obstructing their lived experiences (Melton, 2011). Study participants also reported that in their neighborhoods, socially-identified deviant behavior is frequently interpreted as the cause of having acquired HIV, regardless of the facts (Melton, 2011). In addition, some women interviewed reported how public assistance reform led to their vulnerability to HIV infection (Melton, 2011).

Melton (2011) identifies that the lack of viable opportunities for financial sustenance and economic empowerment, in part produced by welfare reform left women that are transitioning into the workforce vulnerable. Drawing on data from the interviews, Melton (2011) extrapolates that women in the study re-empowered themselves through exchanging sex for money. Findings from this study indicate that Black women living with HIV/AIDS on the margins of society are also “marginalized from the margins” (Melton, 2011 p. 306). Women interviewed explained that their social networks reject people living with the virus (Melton, 2011). Most of the women identified a tension between revealing their status to close friends and family members to maintain support or keeping their status to themselves as a means of avoiding being out-casted
This finding reiterates Michele T. Berger’s (2004) observations of “intersectional stigma” among Black and White women living on the margins with HIV in the US (p. 24). Melton’s (2011) study findings further reveal how social determinants can drive population health and micro-level well-being. The narratives of the women interviewed illustrate that stigma and inadequate public policy worked in synergy to shape their efforts toward HIV prevention (Melton, 2011). As the women reported, being ostracized from networks of support was pivotal in decision-making to forgo primary HIV prevention (Melton, 2011). Two years prior to Melton’s (2011) contribution, Catherine K. Medina (2009) published similar findings.

Medina’s (2009) research explored how heterosexual African American and Latina women make sense of and perceived HIV testing and prevention. Medina (2009) gathered the data through semi-structured interviews with a sample size of 56 women. The tool inquired about the women’s reasons for being tested and whether testing changed their behaviors (Medina, 2009). In addition, the interview examined the women’s perceptions about why people may not get tested and what reasons would influence people to get tested (Medina, 2009). The study interview also asked participants about where they believed HIV/AIDS came from and what was responsible for its spread throughout the US (Medina, 2009). Medina (2009) does not identify the serostatus of the study participants. However, Medina (2009) and the women identify that they are at risk through living on very limited economic means, having an HIV+ partner or having a history of incarceration.

Data from the interviews suggests that although testing can increase safer sex practices, this change is not always maintained (Medina, 2009). Women interviewed identified that their economic status and subjugated social and gender roles in their communities resulted in
vulnerability to contracting or passing on HIV (Medina, 2009). Women reported not being able to predict or negotiate when or how sex took place, especially if in need of housing or money (Medina, 2009). Medina’s (2009) findings suggest that government programs and communities work together to take active measures to address drug use, drug-related activities, gender equality in health decision-making and economic sustenance.

Race and ethnic identity were not focused on as variables in Medina’s (2009) reported findings from the qualitative interviews. However, results from a national telephone survey indicate that African American women are more likely than White women to have reported starting a relationship or engage in transactional sex due to economic constraints (Dunkle, Wingood, Camp & DiClemente, 2010). Medina’s (2009) conclusions reiterate the study findings of Berger (2004) and Melton (2011). While Melton (2011), Medina (2009), and Berger (2004) offer significant insights into HIV prevention among communities of color, their research focuses primarily and particularly on women. Black and African American men who have sex with men, and also have sex with men and women have concomitantly been disproportionately affected by HIV/AIDS (Kaiser Family Foundation, 2012a).

In 2006, Darrell P. Wheeler (2006) published findings from a qualitative study that sought to address the dearth of research among Black and African American men who have sex with men. Wheeler’s (2006) qualitative study explored how Black men that have sex with men identify and make sense of their sexual identities. Wheeler (2006) derived this data from three focus groups with a sample size of 25 Black men. Of this sample, one man identified as a man who has sex with men, eight men identified as bisexual and 14 men self-identified as heterosexual (2006). All of the men reported engaging in sex with females and males during the 12 months preceding the study (Wheeler, 2006). The information that men offered during the
focus groups provide HIV prevention approaches with a plethora of meaningful and important insights. During the focus groups, men identified that terms such as bisexual, gay and queer imply undesirable qualities that are inconsistent with their self-perceptions (Wheeler, 2006).

Wheeler (2006) identifies that men in the focus group referenced these terms in connection to religious doctrines, including behaviors dichotomized by what is considered good and bad. One man shared that to have two sons and be referred to as gay would be greatly embarrassing to him (Wheeler, 2006). This sentiment was reiterated when other men in the focus group identified that there is a female connotation in being the penile-receiving counterpart to the penile-inserting partner (Wheeler, 2006). Study participants expressed that to attribute these labels to them is to suggest that they are lacking in physical stature, societal roles or in virility (Wheeler, 2006).

Wheeler (2006) identifies that to further cultivate an open dialogue that will inform sexual decision-making, the language used must resonate with the people who are at closest proximity to HIV/AIDS prevalence. Economics and drugs emerged throughout the interviews as incentives and buffering agents in same-sex experiences (Wheeler, 2006). However, it is important to note that not all of the experiences shared were hinged on financial desire or need. Some members of the focus groups spoke about exchanging sex for a very expensive pair of shoes. Other members spoke of exchanging sex to pay rent (Wheeler, 2006). Some men expressed having a sense of curiosity about same-sex encounters and expressed an understanding of sexuality as rooted in stimulation more specifically than gender role (Wheeler, 2006).

Findings from the focus groups indicate a necessity to address the contextual factors of role expectations, economic constraints, social isolation, incarceration and substance abuse (Wheeler, 2006). Wheeler (2006) summarizes the study findings by offering that HIV
prevention approaches must address how macro-level factors influence micro-level behaviors within this community. Prevention approaches that do not do so are more likely to produce a response that is decontextualized and ineffective (Wheeler, 2006). Claudia L. Moreno’s (2005) research into contextual factors that place Latina women at risk for HIV infection adds to Wheeler’s (2006) findings and conclusions.

In 2005, Moreno (2005) published findings from a qualitative study that sought to understand the contextual risks of HIV and intimate partner violence that are present for Latina women. Moreno (2005) interviewed 32 Latina women through in-depth face-to-face interviews, focus groups and community meetings. The mean age of the study participants was 43, with a majority of the women being born outside of the US (Moreno, 2005). Ninety percent of the study sample was unemployed with annual incomes of less than $12,000 (Moreno, 2005). All of the women that participated in the study tested positive for HIV (Moreno, 2005). During the interviews, women disclosed their experiences of intimate partner violence and persistent poverty. Data from the interviews indicates that intimate partner violence, persistent poverty and proximity to HIV infection overlap and are inextricably linked (Moreno, 2005). Women reported that despite living in persistent poverty and surviving periods of homelessness, they found ways to generate income to send money home to their families (Moreno, 2005).

Fulfilling this familial responsibility, while already living on economic and social margins, sometimes led women into prostitution, drug use and harsher poverty (Moreno, 2005). Women also reported concomitantly facing legal prosecution for concealing their menial income from such work from public assistance agencies (Moreno, 2005). Seeking and maintaining legitimized employment is also a challenge. Women indicated that HIV medications weakened them, impeding them from maintaining a routine work schedule (Moreno, 2005).
emerged in the findings regarding risking not being hired as a result of disclosing their health status to potential employers (Moreno, 2005). Moreno (2005) identifies that it appeared in the women’s narratives that economic constraints facilitate a cyclical downward pattern into rapidly increasing reliance on a shrinking welfare state.

Moreno (2005) adds that the women’s status as immigrant – for some women, undocumented, further complicated an already complex context. Women reported that the requirement for sponsorship made them vulnerable to abuse, poverty and HIV infection. One woman reported remaining being involved with a wealthy married man because his money helped to sustain her (Moreno, 2005). This man also infected her with HIV. Women who were undocumented reported being forced to stay in coercive relationships and isolation out of fear of being deported or not having sponsorship to legally reside in the US (Moreno, 2005). Moreno (2005) identifies that marionismo and machismo can work to both protect and place Latina women at increased risk of HIV infection. Moreno (2005) explains that “marionismo” emphasizes that women remain submissive, uninformed about sex and eager to please their man or husband in any way (p. 349). Moreno (2005) adds that marionismo requires that women endure infidelity as a means of maintaining peace in the family. In the context of HIV prevalence, Moreno (2005) offers that one way marionismo can serve as a risk factor is that its scripts/narrative render conversations about sexual histories and negotiating condom use as inappropriate for Latina women to discuss with their male partners.

Women in the study identified marionismo and its counterpart, machismo, as a social norm in their families and communities. Most of the women in the study reported having been infected by heterosexual transmission (Moreno, 2005). Moreno (2005) reiterates Wheeler’s (2006) conclusions, deducing that HIV prevention must address structural factors, which include
the context of poverty, discrimination, racism, and historic and present colonization. Moreno (2005) adds that prevention approaches must come from sociocultural definitions of risk and the context of the relationship. Concepts of risk reduction must be informed by cultural scripts of gender and sexual power, including marionismo and machismo (Moreno, 2005). Moreno (2005) offers significant contributions to HIV prevention especially in regard to how macro-policies can inform micro-level context.

Wenzel, Tucker, Elliott and Hambarsoomians (2007) add support to utilizing structural interventions as a component of HIV prevention in the US. In 2007, Wenzel and colleagues (2007) published their findings from a quantitative study that sought to investigate the association between housing status and engaging in sexual risk behaviors. The study sample consists of 833 White, African American and Hispanic women living in shelters and or low-income housing (Wenzel et al., 2007). The study took place in the central region of Los Angeles. Data were gathered through computer-assisted face-to-face structured interviews (Wenzel et al., 2007). Women were asked about sex partners and sexual experiences. Bivariate analyses reveal that African American women experiencing homelessness were more than two times as likely to have multiple sex partners in the past six months, than African American women in stable low-income housing (Wenzel et al., 2007). Similarly, Hispanic women experiencing homelessness were more than four times as likely to having multiple sex partners in the past six months, than Hispanic women living in stable low-income housing (Wenzel et al., 2007).

Findings from this study also indicate that victimization by physical violence and greater drug use severity are among the variables that were significantly associated with having multiple sex partners during the six months prior to the study (Wenzel et al., 2007). Within each of the
race and ethnic groups of the sample, women experiencing homelessness also experienced more physical violence and increased drug use severity than women living in low-income housing (Wenzel et al., 2007). These study findings indicate that housing status can be a risk factor for exposure to HIV/AIDS. Kipke, Weiss and Wong (2007) explored similar questions with young men who have sex with men in Los Angeles.

Kipke, Weiss and Wong (2007) sought to examine what factors are associated with HIV protective and risk behaviors among young men who have sex with men. Participants of the study ranged between the ages of 18 and 24. Eighty one percent of the young men in the study self-identified a same-sex sexual identity or as gay, while 16% of the young men self-identified as bisexual and one percent identified as heterosexual (Kripke et al., 2007). Thirty nine percent of the sample self-identified as Latino of Mexican descent, 37% identified as Caucasian and 24% identified as African American (Kripke et al., 2007). Kripke and colleagues (2007) recruited the young men from public venues known to be frequented by young men who have sex with men. Young men who were eligible to participate in the study were administered an electronic survey that asked about HIV/STI status, drug use, HIV risk behaviors and living arrangements. Study findings indicate that young men who have sex with men that are experiencing housing or residential instability are at significantly higher risk for engaging in HIV risk behaviors, including drug use (Kripke et al., 2007).

A chi-square analysis revealed that African American respondents were less likely to have been forced to move from living with family because of their sexuality. However, they were still more likely to have lived on the street at some point in their life (Kripke et al., 2007). Respondents that had spent some point of their lives living on the street and that, at the time of the study did not have a regular place to stay, were more likely to have engaged in a transactional
sexual exchanges in the six months prior to the study (Kripke et al., 2007). In addition, young men who had at some point lived on the streets and did not have a regular place to stay at the time of the study, were also more likely to report a HIV seropositive status (Kripke et al., 2007). Kripke and colleagues (2007) identify that the study measures of residential instability were strongly and significantly associated with HIV risk behaviors. Study findings from this research indicate that housing in general, and living with family, in particular for young men who have sex with men may serve as a protective factor for HIV risk (Kripke et al., 2007).

**Broader Review of the Literature**

**Macro-Level Influences on Micro-Level Behaviors**

In 1990, Roderick Wallace published findings from a quantitative study exploring the relationship between urban desertification and public health. In the theoretical framework of the study, Wallace (1990) posits that the destruction of housing and community entails/produces a concomitant intensification of risk-taking behaviors and substance abuse. Wallace (1990) identifies that these behaviors are expressed in the footprints and patterns of HIV/AIDS outbreaks. Using data from the New York City Health Department and the US Census, Wallace (1990) analyzed the distribution of deindustrialization, destruction of affordable housing, population migration, mortality, criminalized activities, race/ethnicity demographics and the frequency of HIV/AIDS infections by geographic and social space. Wallace’s (1990) findings indicate that the loss of affordable housing, depopulation and the disruption of community structures and social networks is an ongoing disaster.

Wallace (1990) adds that this ongoing crisis receives very little notoriety in the news media or from public officials. Findings from this study indicate that increased mortality rates,
substance abuse and the distribution of the HIV/AIDS pandemic are associated with this ongoing urban desertification. According to Wallace (1990), the denial of municipal services, especially fire extinguishment resources, have contributed significantly to the conditions that at-risk behaviors are embedded in (Wallace & Wallace, 1990). HIV risk behaviors take place within a context and are an outcome of people on the margins of society negotiating resources that have been eroded in their environments. Wallace (1990) asserts that societal policy has been crucial in creating conditions that are favorable to the spread of HIV/AIDS to and through these geographically stratified communities and spaces. Wallace (1990) suggests that an ecologically-informed intervention that offers service restoration may hold the greatest potential to thwart any further damage of improper policy and HIV/AIDS. Six years later, Wallace and colleagues (1996) would publish a study that echoed Wallace’s earlier findings with the added social context of micro-level social networks.

**The Reaches and Limits of a Geographical Social Network Approach**

In 1996, Wallace, Fullilove and Flisher published findings from a study that investigated the relationship between risk behaviors, social networks, macro-level factors and communities of color. Similar to previous studies, Wallace and colleagues (1996) affirmed that HIV/AIDS cases were disproportionately represented among communities living closest to, and on the margins of US society. However, Wallace and colleagues (1996) added a context for what previous authors had identified as marginalized groups relapsing into engaging in risk behaviors, thus rapidly spreading AIDS within the US. In contrast to this perspective, Wallace and colleagues (1996) assert that behaviorally transmitted infection and disease control information are two components of the same process of information transmission along a channel. The channel in which this information is transmitted is structured by dominant economic, historical and social
externalities. Wallace and colleagues (1996) built on social network theory (Wallace, 1991) adding that geographically-focused social networks exist within these macro-level externalities.

The findings of their study suggest that it is the continued marginalization of subgroups that presents severe and overwhelming constraints on micro-level behaviors (Wallace et al., 1996). Prevention methods that are primarily rooted in using a community’s own social network for the dissemination of harm-reduction information are thus, limited by these structural-level constraints (Wallace et al., 1996). Wallace (1994; 1991) indicates that the same conditions that enable HIV/AIDS to spread within a community can also serve as the pathways for the virus to spread to other communities, regardless of geographical distance. Heckathorn, Broadhead, Anthony and Weakliem (1999) published findings from a study that continued to explore the use of social networks as a vehicle for HIV prevention. The findings from Heckathorn and colleagues (1999) suggest that a network intervention to HIV risk can be effective when certain features of this network are present. One of these features includes the network engaging in risky behaviors. The study adds to the information base of how social networks can serve HIV prevention approaches. However, the theoretical framework and study approach underscore that people spread the virus, rather than the constraints present in the environments in which people are immersed. Heckathorn and colleagues (1999) do not provide a macro, social, political, historical or economic context for the behaviors that they are working to prevent or further inform. In its place, Heckathorn and colleagues (1999) offer the study finding that just as networks have the potential to spread AIDS, they also have the potential to facilitate interventions.

Similarly, Pilowsky and colleagues (2007) explored the associations between social network characteristics, sexual practices and drug use among young adults in Harlem and the
South Bronx. Findings from this study indicate that an association exists between a network that includes a high proportion of drugs and the risk of engaging in HIV risk sexual behaviors (Pilowsky et al., 2007). Three years later, Castor and colleagues (2010) published findings from this randomized control trial that sought to reduce sexual risk among people that use non-injection drugs and their peers. Castor and colleagues (2010) report on an intervention based on the social influencing approach. A social influencing approach proposes that people are more likely to adopt new behaviors if members of their social networks adopt these new behaviors at the same time (Castor et al., 2010).

Findings from this research indicated that there were no significant differences in HIV and high-risk sexual behaviors between the intervention group and the control group (Castor et al., 2010) at 9 and 12-months post-intervention. Although these studies reaffirm the importance of social networks, the authors do not speak to how this approach may be supported or thwarted by factors outside of the network’s control or access. Without the inclusion of the macro context, the study findings affirm opinions that the communities with the highest rates of HIV/AIDS are vectors and epicenters of the disease. The secondary data analysis conducted for this dissertation was derived from the dataset of the randomized control trial conducted by Hadden, Pilowsky and colleagues (2010) with non-injection drug users in Harlem and the South Bronx, and will add the macro-lens that the study lacked.

Studies have also explored the power of African-American communities to organize around preventative and restorative approaches to HIV/AIDS. In 2004, Marcus and colleagues (2004) published findings from a participatory research project carried out in an African American church setting. This project sought to explore the use of participatory research as a grassroots response to the complex health issues within the communities afflicted by these health
issues (Marcus, Walker, Swint, Smith, Brown, Busen et al., 2004). The focus of this project was to create and carry out a three-year intervention to reduce substance abuse and HIV/AIDS rates among African American adolescents. University-based investigators and African American church member stakeholders collaborated on the design, implementation and evaluation of the faith-based program (Marcus et al., 2004).

The findings from the evaluation of this project suggest that adolescents that were involved in the program were less likely than the control group to endorse drug use of any kind, including cigarettes, marijuana and alcohol (Marcus et al., 2004). Adolescents in the program were also more likely than the control group to express a fear of contracting HIV/AIDS and to ask a close family member about substance use and HIV/AIDS. Marcus and colleagues (2004) offer the strong findings for a very successful approach to HIV/AIDS prevention in a faith-based African American community. Such a program may be replicable in other communities with high rates of HIV/AIDS. This study design incorporates the theoretical framework and approach that communities most afflicted with HIV/AIDS are also capable of actively participating in research about this health crisis. This shift in role renders individuals and families of these communities as more than just the subjects of research (Smith, 1999).

**HIV/AIDS Prevention in Black, African American and Latina/o Communities**

**Inclusion of Context and Identify toward a Means of Prevention**

In 1990, Fullilove, Fullilove, Haynes and Gross carried out a qualitative study that explored how 28 Black or African American women experience gender roles in regard to sexual behavior. Comments from the intensive group discussion illustrate that traditional sex and gender roles are present in these communities. These traditional roles permit men to have sexual freedom but censure women from engaging in the same activities, in the same way (Fullilove et
al., 1990). Findings from this study also suggest that a significant problem in heterosexual relationships is the dearth of effective communication about sexual behaviors and condom usage in regard to partial monogamy (Fullilove et al., 1990). Fullilove and colleagues (1990) further add that these challenges in communication are reflective of power imbalances between the genders and reflective of economic shifts affecting this community.

The analysis in the study by Fullilove and colleagues (1990) reveals that it is imperative for HIV/AIDS prevention approaches to encompass a means of communicating that will re-empower Black and African American women to negotiate with their male sex partner(s) about the parameters and practices of the sexual activity and the relationship. This study does not offer an approach to the macro-level factors that it identifies as creating an environment of constraints. However, Fullilove and colleagues (1990) offer the social context as described by the study participants. Including the contexts of the study participants may further inform HIV/AIDS prevention strategies of how to more effectively address rates of HIV/AIDS in Black, African American and Latino/a communities.

In 2006, Wheeler (2006) published findings from a qualitative study exploring how Black African American men that have sex with men identify their sexual identity and how they view HIV preventions. Findings from this focus group illustrate that many Black and African American men that have sex with men do not identify with or describe themselves using the sexual identity labels of bisexual, gay or homosexual (Wheeler, 2006). The study design, approach and findings illustrate that Black and African American men have valuable insight into their own life experiences regarding HIV risk to themselves and their female partners (Wheeler, 2006). Study findings assert the need for prevention methods to incorporate a recognition of structural factors that impact and are the context for sexual risk behaviors (Wheeler, 2006).
Finally, the responses of the study participants demonstrate their capacity to occupy leadership positions and roles in prevention approaches, as opposed to being limited to just being the consumers of the service (Wheeler, 2006). Wheeler (2006), Fullilove and colleagues (1990) add to research developing a stronger awareness of the context within which the sexual risk taking occurs. This approach and their study findings have made very significant and meaningful contributions to research in HIV/AIDS prevention among the communities with the highest rates of this infection.

**Condom Use and Barriers to Condom Use**

Researchers have also explored barriers and access to methods of safer sex practices among communities of color. In 1992, Marin and Marin (1992) published findings from a quantitative study that identified the factors that are associated with condom accessibility among Latinos and Latinas in San Francisco. Marin and Marin (1992) found that Latino men reported having, keeping or carrying condoms at more than twice the rate of Latina women. Additionally, Latino men reported higher levels of sexual risk taking (Marin & Marin, 1992). The findings of this study add to and reiterate the study findings of Fullilove and colleagues (1990). Both studies explored barriers to condom usage. While Marin and Marin (1992) were able to access knowledge regarding access to condoms, Fullilove and colleagues (1990) were able to gain access into the context within which the negotiation of condom use takes place.

In 2000, Soler and colleagues (2000) published a study that explored rates of and barriers to condom use among Black or African American, Latina and White/Euro-American women. The purpose of their study was two-fold. First, these researchers sought to distinguish the associations between relationship dynamics and consistency of condom use. Second, Soler and colleagues (2000) were interested in distinguishing this relationship as a means of adding to the
understanding of ethnicity and racial differences in condom use with a main partner. Soler and colleagues (2000) found that women who made financial decisions independently were more likely to use condoms consistently. Women that shared financial decision-making and women that did not participate in financial decision-making were between 80% and 90% less likely to use condoms consistently (Soler et al., 2000).

Despite this finding, Soler and colleagues (2000) do not make any recommendations to intervene in economic structural factors that expand or contract the opportunities for financial independence of women, particularly, women at risk of HIV infection. Additional findings from this study illustrated that Black, African American and Latina women reported more consistent condom use than White/Euro-American (Soler et al., 2000). According to the responses of the women in the study, Black, African American and White/Euro-American women express greater comfort in direct methods of communication (Soler et al., 2000). Latina women expressed greater comfort in indirect ways of negotiating condom use (Soler, et al, 2000). Soler and colleagues (2000) assert that HIV prevention programs must incorporate the myriad ways that members of various ethnic and racial groups communicate about sex practices and protection. This assertion reiterates the earlier work of researchers Kalichman, Kelly, Hunter, Murphy, and Tyler (1993).

**Incorporation of Culture as a Means of Strengthening Prevention Efforts**

In 1993, Kalichman and colleagues published their findings from a study that explored the influence that culturally tailored HIV/AIDS risk reduction messages have on risk sensitization and risk reduction. Kalichman and colleagues (1993) recruited 106 African American women from a low-income housing project in Chicago to participate in their study. The study participants were randomly assigned to view one of three 20-minute videotapes of
how to prevent AIDS. The first videotape was a standard public health service tape with no presenter. The second videotape included the standard public health service tape with a presenter who was matched to the ethnicity and sex of the participants. The third videotape was of the same content and a presenter of the same ethnicity and sex of the participants who also framed the context of the information with the deliberate intent to increase its cultural relevance (Kalichman et al., 1993).

Findings from the study identify that the tape that included an African American woman presenter who framed the content of the tape in a culturally relevant context was most effective in influencing the study participants to get tested and request condoms post the viewing of the tape (Kalichman et al., 1993). Kalichman and colleagues’ (1993) findings affirm what Fullilove and colleagues (1990), Wheeler (2006), and Wheeler and colleagues (2010) have continued to assert the need for incorporating cultural values that are related to ethnicity, family and community because they influence the study participants’ perceptions of their risk for HIV/AIDS (Kalichman et al., 1993). Setting the stage for and building on the contributions of these authors, other researchers have conducted reviews of the efficacy of HIV behavioral prevention in African American communities.

**Risk Behaviors and Risk Behavior Prevention**

**Anal Sex in Heterosexual Sexual Encounters**

In 1988, Jaffe, Seehous, Wagner and Leadbeater published their findings from a study that explored anal intercourse and knowledge of AIDS among Black or African American and Latina heterosexual adolescents. Study findings suggested that 25% of the study sample had engaged in anal sex. In addition, condoms were less likely to be used during anal sex than during vaginal intercourse. Although there was a positive correlation between age and
knowledge, there was no relationship between age and any change in sexual behaviors to avoid contracting HIV (Jaffe et al., 1988). Through their study, Jaffe and colleagues (1988) offer confirmation that anal sex takes place in heterosexual relationships. However, the authors dangerously and erroneously interpret this finding as indicative of a high incidence of anal sex relative to the race and ethnicity of the study sample (Jaffe et al., 1988).

In 1995, Erikson and colleagues (1995) published the findings from a study that explored the prevalence of anal sex among heterosexual adults. The findings from this study reiterated Jaffe and colleagues’ (1988) assertion that anal sex takes place in heterosexual relationships (Erikson, Bastani, Maxwell, Marcus, Capell & Yan, 1995). Erikson and colleagues (1995) also found that 60% of the adults who reported having engaged in anal sex also reported not using condoms during anal sex. Both of the aforementioned studies have called attention to the frequency in which anal sex may or may not take place in heterosexual relationships (Jaffe et al., 1988; Erikson et al., 1995). However, study findings from Baggaley, White and Boily (2010) have called attention to the need for researchers to generate a fuller understanding of the context within which anal sex takes place. The study findings from Roye, Toleman and Snowden (2012) reiterate this call to action. Wheeler and colleagues (2010) have gone further to illustrate the need for research to generate a fuller understanding of identity, sexual identity and the sexual contexts of Black, African American and Latino/a experiences in the US.

**Behavioral Risks through the Lens of Race, Ethnicity and or Sexual Identity**

Racial disproportionality of HIV/AIDS in the US has been an ongoing issue throughout HIV/AIDS research. Some researchers have sought to make sense of these rates by exploring race and sexual identity-based differences in sexual practices, uses and non uses of protection. In 1994, Lemp, Hirozawa, Givertz, Neri, Anderson, Lindegren, Janssen and Katz (1994)
published findings that indicate that young men who identify as either homosexual or bisexual are at significant risk of HIV infection. Seventy percent of the men who participated in the study and tested positive for HIV were unaware of their seropositive status (Lemp et al., 1994). According to Lemp and colleagues (1994), one third of the participants reported having engaged in unprotected anal intercourse. Similarly, in 2002, Wohl, Johnson, Lu, Jordan, Beall, Currier and Simon (2002) published findings from their research into HIV risk behaviors among African American men who self-identify as heterosexual. Their findings suggested that 47% of the participants reported having anal sex with men (Wohl et al., 2002). Within the study sample, 67% of the men with seronegative status and 100% of the men with seropositive status reported infrequent condom use in anal sex (Wohl et al., 2002). Roughly half of the study sample reported infrequent condom use in anal sex with women (Wohl et al., 2002).

This same year, a group of researchers published findings from their study that explored if a history of trauma contributed to HIV risk for African American and Latina women. Wyatt, Myers, Williams, Kitchen, Loeb, Comona, Wyatt, Chin and Presely (2002) explored the relationship between history of trauma, race/ethnicity and HIV risk for women of color and White/Euro-American women. Findings from this research indicate that race and ethnicity are not independent predictors of HIV-related risk (Wyatt et al., 2002). Study findings identify that women with seropositive status reported more sexual partners, a history of transmitted diseases and more severe histories of abuse than did women with seronegative status (Wyatt et al., 2002). Wyatt and colleagues (2002) offer that high risk behaviors, limited material resources and exposure to violence, were the best predictors of HIV risk for the participants of the study.

Five years later, Moreno, El-Bassel and Morrill (2007) published findings from a study that explored sexual risk factors for HIV among heterosexual Latina and African American
women. Contrary to some of the insights from Wyatt and colleagues (2002), findings from Moreno and colleagues’ (2007) study indicate that African American women are more likely than Latina women to have had more sexual partners in their lifetime, have had a sexually transmitted infection in the past and to have reported using condoms with their main sexual partner (Moreno et al., 2007). All of these studies have offered insights into disproportionate rates of HIV prevalence and sexual practices that may, and may not be taking place among communities in closest proximity to the HIV/AIDS pandemic. This information is crucial in constructing effective prevention approaches (Hadden, 1998). However, this information alone, without knowledge of the context within which these behaviors are taking place is not enough to construct effective measures to reduce HIV/AIDS prevalence among the mentioned communities (Wheeler et al., 2010; Wheeler, 2006). Findings offered by Wyatt and colleagues (2002) may be a step in this direction in that their findings illuminate the relationship between seropositive status, limited material resources and exposure to violence.

In 2011, Villar-Loubet and colleagues (2011) investigated the influence of ethnicity and HIV serostatus on male or female condom acceptability among Latina and African American women. Similar to the work of Moreno and colleagues (2007), Villar-Loubet and colleagues (2011) found that male condom acceptability was higher among African American women than Latina women at the baseline interview and in the 12-month follow up interview. The findings of this research identify that African American women offered the most positive perceptions of male condoms throughout and after the study. Villar-Loubet and colleagues (2011) suggest that ethnicity should be considered in the development and marketing of sexual products in addition to offering a cost effective female condom option. This insight is a step in the direction of learning more about the context sexual practices take place within. However, without greater
knowledge about this context, an affordable or prettier packaged product will not necessarily render it more usable, reachable or desirable (Wheeler et al., 2010).

**Review of HIV Behavioral Prevention Research about African Americans**

In 2002, Darbes, Kennedy, Peersman, Zohrabyan and Rutehrford (2002) published their findings from their systematic review of the literature on HIV prevention among African American communities. Darbes and colleagues (2002) found that the most successful interventions contained the components of cultural sensitivity and responded to the unique experiences of African Americans, were conducted over multiple sessions and provided the participants with skills-training. Some of the examples of positive outcomes of the studies reviewed included having increased communication with sex partners regarding protection and sex practices, increased condom use and decreased needle sharing (Darbes et al., 2002). Darbes and colleagues (2002) added to the growing body of research a call to incorporate the context of the population that the prevention is intended to reach. Incarcerated populations were not mentioned and likely, not represented in the studies that Darbes and colleagues’ (2002) reviewed. Becky Pettit (2012) elaborates on how incarcerated populations are rendered invisible in much research and statistics by not being represented in the study samples. This trend is reflective of the neglect in much of the research into HIV/AIDS prevention, of the contribution of structural factors to disproportionate HIV infection in communities of color.

In 2005, Belenko, Shedlin and Chaple (2005) spoke to this dearth of representation and interviewed 300 New York City incarcerated men and women between 2001 and 2002. Findings from these interviews indicate high rates of HIV risk-taking and high rates of HIV infection despite high levels of HIV knowledge (Belenko, Shedlin & Chaple, 2005). Belenko and colleagues (2005) further identify the inconsistent access that people who are incarcerated have
to HIV prevention and effective education services in correctional settings. These researchers reiterate the assertions of previous studies, while adding the contexts of open and housed incarceration. Belenko and colleagues (2005) call for the expansion of peer-led, culturally relevant, gender specific interventions for people that are incarcerated, on probation or on parole. In addition, Belenko and colleagues (2005) indicate a need to expand HIV/AIDS prevention, and Arp III (2004) points to a need for greater focus on the salient issues that are unique to African American experiences.

In 2004, Arp III published findings from a study where he reviewed the prevention strategies of three agencies operating in the state of Louisiana. All three agencies served Black and African American communities. Findings from this study indicate that all of the agencies successfully carried out their strategies to reduce HIV/AIDS rates in the three communities that they served (Arp III, 2004), but did not reduce or stop the increase of HIV/AIDS within the geographical communities that they serve (Arp III, 2004). Arp III (2004) insightfully asserts that Louisiana state HIV/AIDS prevention policy must allocate adequate resources in communities with high rates of HIV infection to address the salient issues that impede on prevention approaches. Arp III (2004) reiterates the conclusions of previous research findings (Wallace and colleagues, 1996; Wallace, 1994; 1991a).

**HIV/AIDS Stigma and Social Context**

**HIV/AIDS Stigma**

In 2003, Clark, Lindner, Armistead and Austin (2003) published their findings from a study investigating how stigma informs disclosure and psychological functioning among African American women with seropositive status. Clark and colleagues’ (2003) research had two purposes. First, they wanted to explore how AIDS-related stigma was experienced among
African American women living with seropositive status and seronegative status. The second purpose was to examine how the disclosure of status mediated the relationship between stigma and psychological wellbeing. The findings of this study identify that African American women living with seropositive status reported having experienced a higher level of AIDS-related stigma than the group of African American women with negative serostatus at all levels of the study (Clark et al., 2003). Findings from this study indicated that the more stigma women with seropositive status encountered, the less they disclosed their status and the lower they scored on the psychological wellbeing scales (Clark et al., 2003).

In 2006, Buseh and Stevens (2006) documented similar results in their research into how African American women navigated AIDS-related stigma. However, Buseh and Stevens (2006) add a lens of African American women resisting AIDS-related stigma. For their study, Buseh and Stevens (2006) analyzed the qualitative interviews of 29 African American women living with seropositive status. Each of the participants of the study narrated her life since receiving a positive diagnosis in interviews that were conducted over the course of two years. The findings from this study identify and affirm previous research findings that AIDS-related stigma manifests on individual, social and institutional levels (Buseh & Stevens, 2006). Findings from this study further inform researchers of the ways that women living with HIV infection resist the social isolation, inner feelings of despair, and institutional disregard that AIDS-related stigma can produce (Buseh & Stevens, 2006). Participants reported that they resisted AIDS-related stigma by learning to disclose only at strategic times, enlisting support and redefining stigma as ignorance (Buseh & Stevens, 2006).

The authors offer the findings of the study as starting points for creating participatory interventions for and with African American women that are living with HIV. In both their
findings and study approach, Buseh and Stevens (2006) offer African American women living with seropositive status a platform to describe the context within with they live with HIV and navigate stigma; micro-level expressions of macro-level factors. Similarly, Leith Mullings published a study in 2005 that explores the role of structural factors as they are expressed in micro-level conditions on the health of Black and African American women in Harlem.

Social Context

In 2005, Leith Mullings published findings from a mixed-method study that explored the effects of macro structures such as gender subordination, class exploitation, and racial discrimination on the health and wellbeing of Black and African American women in Harlem. Macro-level structures were explored in their expression through environmental racism, employment insecurity and poor housing or living conditions (Mullings, 2005). In the theoretical framework for her research, Mullings (2005) offers that utilizing an intersectional approach in the sense-making of risk behaviors and health outcomes informs social scientists about racially disproportionate health disparities more than explanatory paradigms of assumed lifestyle choices or biological attributes of race. An intersectional approach is the simultaneous examining of race, class and gender as interlocking systems of oppression and societal stratification (Schulz & Mullings, 2006; Mullings, 2005). Mullings’ (2005) findings indicate that Black and African American women assume community, economic and household responsibilities. The taking on of these responsibilities is expressed in their consistently addressing the need of community re-empowerment, serving as the heads and matriarchs of households and working outside the home. Mullings’ (2005) findings add that these roles are frequently carried out in environments and conditions that are made even more challenging by limited resources and various forms of class, gender and race discrimination.
Mullings (2005) did not specifically explore HIV/AIDS and risk behaviors among Black and African American communities. However, Mullings’ (2005) research makes a significant contribution to the framework of how social scientists make sense of this phenomenon within the community that is most disproportionately represented in this endemic. Mullings (2005) posits that this study underscores the essentiality of examining the social conditions that produce the environmental and biological processes that serve as pathways of unequal exposure to harmful pathogens, including HIV/AIDS. Mullings (2005) concludes that although race is not a biological fact, the social, political and economic construct of race has dire biological consequences.

In 2007, Wenzel, Tucker, Elliott and Hambaroomians (2007) investigated the relationship between housing status and HIV risk behaviors among African American and Latina women. Wenzel and colleagues (2007) interviewed 833 women living in shelters or low-income housing. Study participants were asked about their experiences of drug use, violence and perception of HIV risk. Findings from this study indicate an inverse relationship between housing status and sex risk behavior (Wenzel et al., 2007). Bivariate analysis illustrates that homeless women were between two and six times more likely to have reported having multiple sex partners in the past six months prior to the study, than women with stable living conditions (Wenzel et al., 2007). Reiterating the findings of Mullings (2005), Wenzel and colleagues (2007) report that the variance in risk behavior between women housed in stable conditions and women living in shelters were accounted for by several factors. These factors included housing status, recent victimization through physical violence and severity of drug use (Wenzel, et al., 2007).

colleagues (2009) posited that racially disproportionate rates of HIV/AIDS in communities of color are in part the result of concurrent sex partnerships. The study analyzed descriptive data for four representative nationally based surveys. Findings from this study suggest that Black, African Americans and Latinos/as are more likely to engage in concurrent sexual partnerships than White/Euro-Americans (Morris et al., 2009).

The authors of the study assert that prevention programs must do more to stress the message of “one partner at a time” (Morris et al., 2009, p. 1029). Reflective of Wenzel and colleagues (2007), Morris and colleagues (2009) identify the necessity to address the context that these behaviors are taking place in. Unlike Mullings (2005), Wenzel and colleagues (2007), and Morris and colleagues (2009) do not define what they mean by this context or how it can translate into further research or HIV prevention methods. Thus, the findings of this study may do more to promulgate antiquated and misunderstood contexts of Black, African American, and Latino/a sexuality than to add clarity to how researchers understand the contexts of sexual experiences (Wheeler et al., 2010).

**Theoretical Discourses Relevant to the Proposed Research**

**Influence of Macro Factors on Public Health**

There are three theoretical discourses that are directly relevant to the proposed research. The first colloquy promulgates the influence of macro determinants of public health. The CDC (2012), Denning and DiNenno (2010), and the Kaiser Family Foundation (2009) illustrate that the distribution of HIV/AIDS infections in the US is stratified by race, poverty and gender. Since the 1980s, HIV/AIDS prevention has been heavily informed by individual-level behavioral interventions (Dean & Fenton, 2010; Kull, 2010). These interventions have sought to promote condom use and distribute information about sexual and drug use health (Dean & Fenton, 2010;
Denison, 2002). Individually-rooted means of HIV/AIDS prevention have garnered significant successes (Darbes, Crepaz, Lyles, Kennedy & Rutherford, 2008; Davis & Weller, 1999). However, this approach has not been successful in achieving sustained reductions in HIV/AIDS incidence or in eliminating the health inequities that are reflective in the distribution of the infections (Dean & Fenton, 2010), particularly among Blacks, African Americans and Latino/as.

Satcher (2010) defines health inequalities as systematic disparities that are both unjust and avoidable. According to Satcher (2010), it is the inequitable distribution of healthy and unhealthy social conditions across communities that serve as pathways for persistent health inequalities. Satcher (2010) reiterates the World Health Organization’s (2008) assertion that the single most important determinant of a person’s health status is the social condition into which they are born, live and work. Florey, Galea and Wilson (2007) explicate this in the framework they offer for their theory of macro-social determinants of population health. According to this framework, global-level factors inform national-level factors, which then inform community-level factors (Florey, Galea & Wilson, 2007). Global-level factors include population movement, income distribution, global trade and global governance (Florey, Galea & Wilson, 2007). National-level factors include employment, governance and policies, population density, employment and infrastructural resources (Florey, Galea & Wilson, 2007). Community-level factors include population heterogeneity, social environment, resource allocation, social services and physical environment (Florey, Galea & Wilson, 2007). These three-tiered factors work synergistically to create social, economic and political environments that constrain or support individual-level choice making.

In response, Green and Ruark (2011) assert that macro-level change does not in itself directly prevent the transmission HIV/AIDS. Green and Ruark (2011) identify that the spread of
HIV is directly prevented by sexual abstinence or mutual monogamy with an uninfected partner, or by using condoms, male circumcision, and treatment of STIs. Dean and Fenton (2010) assert that high risk behaviors that occur on an individual level are among the more significant drivers of HIV/AIDS acquisition risk and transmission. Dean and Fenton (2010) also observe that individual-level behavior takes place within the contexts of sexual and non-sexual partnerships. Furthermore, these partnerships are themselves, located in a wider network of relationships (Dean & Fenton, 2010).

Friedman, Rossi and Phaswana-Mafuya (2009) reiterate this concept when they postulate that social and economic change at a macro level informs people’s lives and micro-level social interactions. Micro-level social interactions, in turn, affect how and where HIV/AIDS does and does not spread. Concomitantly, greater understanding of the pathways through which HIV/AIDS is transmitted enables public health practitioners to understand how to effectively reduce the prevalence of these infections (Friedman, Rossi & Phaswana-Mafuya, 2009). Dean and Fenton (2010) add that the circumstances in which people live, grow, work, love, socialize and form relationships are directly shaped by political, social and economic forces. The patterns of distribution of HIV/AIDS are further influenced by a turbulent interplay between the range of past and present governance policies, the efficacious/inefficacious preventative interventions and the prevalence of the infectious virus (Dean & Fenton, 2010). Several authors have applied this perspective to the disproportionate rates of HIV/AIDS present in Black, African American and Latina/o communities in the US.
Influence of Structural Factors on the Health of Black, African American and Latinas/os


Friedman and colleagues (2009a) insightfully identify that although Black and African American communities have the highest rates of HIV/AIDS, they do not have higher rates of engaging in sexual risk behaviors than other ethnicities/races. Furthermore, Blacks and African Americans are not more likely to use drugs than any other ethnic or racial groups (Friedman et al., 2009a; Laurencin et al., 2009). Laurencin and colleagues (2009) reaffirm this by adding that African Americans report less risky practices and drug use than White/Euro-American communities. Despite these research findings, rates of HIV/AIDS among African Americans are not declining (CDC, 2012; Laurencin, Christensen & Taylor, 2008; Smith et al., 2000). Researchers have posited that explanations for disproportionate rates of HIV/AIDS in Black and African American communities are likely rooted in race, gender and economic-based oppression (Wheeler et al., 2010; Friedman et al., 2009a; Fullilove, 2006).

Examples of this race, gender and economic-based oppression include, but are not limited to economic deprivation, inadequate access to medical and social care, and discriminatory rates
of arrest and incarceration (Friedman et al., 2009a; Fulilove, 2006; Mullings, 2005). Smith and colleagues (2000) have suggested that macro-environmental factors be studied as a means of identifying possible HIV/AIDS intervention components. Macro-level interventions used as components of individually-based methods of HIV prevention may increase access to or use of therapies that are effectively slowing HIV/AIDS transmission among other communities (Freudenberg, Fahs, Galea & Greenberg, 2006; Smith et al., 2000).

Adimora and colleagues (2009) affirm this suggestion in explaining that sexual network patterns are inextricably shaped by the economic and social environment in which many African Americans live, work and form social ties. Similarly, Marin (2003) identifies homophobia, poverty and racism as underlying factors of the high rates of HIV in Latina/o communities. Adimora and colleagues (2009) posit that the conditions present in these social and economic contexts increase individual infection risk almost independently of micro-level behavior. The findings of previous research that Blacks, African Americans and Latinas/os have the highest rates of condom usage of any racial or ethnic group affirms this insight (Reece, Herbenick, Schick, Sanders, Dodge, Fortenberry, 2010).

**Poverty, Homelessness and Incarceration as Pathogenic Pathways**

The third theoretical discourse identifies poverty, homelessness and incarceration as pathogenic pathways for HIV/AIDS transmission. Researchers continue to identify poverty, homelessness and incarceration as pathways through which macro-level systems constrain and support micro-level behaviors. Increased acquisition risk of HIV continues to be associated with poverty, incarceration and chronic joblessness (Bowleg & Raj, 2012; Denning & DiNenno, 2010; Fareley, 2006). Blacks, African Americans and Latinas/os continue to be disproportionately represented among families living in poverty (Denning & DiNenno (2010),...
incarceration (Harawa & Adimora, 2008; Iguchi et al., 2005) and experiencing homelessness (SAMSHA, 2011). Furthermore, these macro-level factors and their footprints are worsened by the legacy of institutionalized oppression, particularly among these communities (Bowleg & Raj, 2012; Marin, 2003). Bowleg and Raj (2012) and Marin (2003) observe that HIV/AIDS is not randomly distributed among Black, African American and Latina/o communities. The communities with the highest HIV/AIDS rates in the US continue to be the same communities living on the economic, social and political margins of society.

Farely (2006), reiterating the work of Williams (1997), postulates that race and ethnicity serve as markers for group, social and environmental factors. These factors explicate the relationship between institutionalized discrimination and disproportionate rates of STIs among Black and African American communities (Farely, 2006). Hallfors, Iritani, Miller and Bauer (2007) did not investigate the possible relationship between institutionalized discrimination and disproportionate rates of STDs among communities of color, but their research findings have led them to very similar conclusions (Hallfors et al., 2007).

**How Reported Findings Bear on the Research Question**

All the findings shared above, illustrate that macro-level factors disproportionately and negatively affect Black, African American, and Latina/o communities in the US. Economic, political, social, environmental and historical constraints are facilitated by macro-level factors. Reported findings suggest that these constraints form conditions that may inform, and at times impede individual, family and community-level decision-making. Study findings also suggest that micro-level agency in the context of navigating constraining conditions can include engaging in HIV/AIDS risk behaviors. Researchers identify that engaging in transactional sex, drug use, experiencing criminalization, having little to no support to exit or remove themselves
from abusive relationships, to access to culturally appropriate methods of safer sex, all
disproportionately place people of color at increased HIV/AIDS risk -- even when less risky
methods of sex and protection are practiced. Closer proximity to HIV/AIDS infection is
reflected in Black, African American and Latina/o communities illustrating the highest rates of
HIV new infections, older infections and virus-related deaths in the US. Additionally, people
living at or close to poverty, experiencing homelessness or incarceration disproportionately test
positive for HIV.

The conceptual findings presented inform the proposed research which hypothesizes that
a relationship between macro-level factors and micro-level behaviors exists. Findings inform the
research question that macro-level policies and institutions may be predisposing Black, African
American and Latinas/os to engaging in HIV risk behaviors. Empirical findings inform the
proposed research that people living without housing, economic means, familial or social support
experience environmental constraints that increase proximity to HIV/AIDS infection. Study
findings also indicate that communities and individuals that are socially and politically identified
as social outcasts may also be predisposed to being in increased proximity to HIV infection. All
of the presented findings above lend support to the study hypothesis that infers a relationship; a
macro/micro relationship and the potential of this relationship to predispose communities of
color to engaging in HIV risk behaviors.

Analysis, Assessment and Evaluation of the Literature

Major Trends, Inconsistencies and Key Debates in the Findings

Satcher (2010), Floery and colleagues (2007) agree that current approaches to reduce
health inequities lack a macro-determinants of health lens. Dean and Fenton (2010) add that a
social determinants of health lens is imperative in approaches to prevent and control HIV/AIDS.
Green and Rurak (2011) disagreeably express a skepticism regarding the efficacy of a macro approach to HIV/AIDS prevention and control. These authors identify a dearth in empirical support for a macro-determinants of health approach as a means of changing individual decision-making (Green & Ruark, 2011). However, numerous study findings indicate that individual actions are informed by navigating constraining environment conditions, which are themselves imbedded in social order (Friedman et al., 2009b; 2007). Friedman and colleagues (2009a; 2009b; 2007) identify that individual decision-making is a direct response to macro-level policies. Several researchers address the implications of these and similar findings when applied to HIV/AIDS rates in Black, African American and Latina/o communities in the US.


Researchers add disproportionate rates of incarceration, living in or close to poverty and stigma as drivers of HIV/AIDS infection that are related to higher-order social structures (Wheeler et al., 2010; Fullilove, 2006; Mullings, 2005; Marin, 2003). The stigma that is being referred to here is related to drug use, citizenship status, ethnicity, gender, race, sexual identity and seropositive status. HIV and AIDS rates have also been identified as traits of the historic and present marginalized status of low-income communities and communities of color in the US.
(Wheeler et al., 2010; Fullilove, 2006; Mullings, 2005; Marin, 2003). Concomitantly, numerous authors continue to add to the theoretical discourse of how incarceration, poverty, alcohol and drug marketing and chronic joblessness function as pathways to HIV/AIDS infection (Harawa et al., 2008; Hallfors et al., 2007; Farley, 2006; Iguchi et al., 2005). An empirical base linking macro-level factors to increased prevalence of HIV risk among Black and African American communities is growing (Bowleg & Raj, 2012; Auerbach et al., 2011).

Arp’s III (2004) findings indicate the limited reach of individually-based methods of HIV/AIDS prevention in Black and African American communities. Studies identify a possible and plausible association between law enforcement, criminalizing justice and pandemic HIV/AIDS rates among Black, African American and Latina/o communities (Friedman et al., 2006; Belenko et al., 2005). Research also illustrates the significant role of housing in increasing or constraining proximity to HIV risk-behaviors (Kipke et al., 2007; Wenzel et al., 2007). Qualitative data supports these findings. Research participants have described how the same behaviors that place them at risk for HIV/AIDS have also been the same behaviors that assist them in evading stigma (Melton, 2010; Wheeler, 2006), avoiding deportation (Moreno, 2007), staying clear of being criminalized by government programs (Medina, 2009) and surviving living in poverty (Berger, 2004).

The presented studies illustrate a trajectory of how the relationship between macro-level factors and micro-level behaviors have been theorized, conceptualized and studied. The studies and findings demonstrate the importance of the conducted research in two ways. First, the research findings will add to the knowledge-base of what an abundance of research, statistics and policy initiatives have identified as one of the leading health crises of the 21st century. Findings of the conducted research further inform social work practitioners, social work policy makers
and social work researchers of the role that structural interventions can play in HIV/AIDS prevention. Research findings indicating that that micro-level policies predispose micro-level individual HIV risk-taking are integral in informing effective and ethical social work practice with individuals, communities and policy making.

**Limitations**

The trajectory of how HIV/AIDS has been studied, theorized and conceptualized in populations of color provided a knowledge-base for the conducted research. Empirical dialogues indicate the need to continue research into this relationship. Research presented throughout this dissertation provides evidence to support a relationship between macro-level factors and micro-level behaviors. However, there is a dearth of quantitative research that specifically ascertains if macro-level factors predispose marginalized communities to engaging in HIV risk behaviors (Green & Ruark, 2011). Most of the studies presented that suggest a predisposing relationship between macro-level factors and micro-level actions are qualitative and have small sample sizes.

Therefore, their study findings are not representative of the larger population from which the samples have been drawn. Although qualitative studies permit generalizations about the phenomenon studied, they do not permit for generalizations from the sample to the population from which they were drawn. The findings of this study make a significant contribution to filling this knowledge gap, and provide the beginnings for studies that are more representative and therefore, permit generalizeability. This dissertation research statistically analyzed the relationship between macro-level factors and micro-level behaviors as a means of investigating if the former predisposes communities of color to engaging in HIV risk behaviors.
Current State of Knowledge in HIV/AIDS Research

Green and Ruark (2011) call for increased empirical research into utilizing a macro-determinants of health approach as an efficacious means of changing micro-level sex-risk behaviors. However, Friedman et al’s (2006; 2007; 2009b) study findings indicate that structural-level polices form environmental constraints. These environmental constraints are imbedded in individual-level contexts and determine what options are or are not accessible in individual decision-making about how to navigate day-to-day life experiences. These day-to-day life experiences include whether or not it is feasible to avoid HIV sex risk behaviors on-route to having basic needs met. Friedman and colleague’s (2006) study findings reiterate this point in adding that punitive law enforcement policies were less likely to deter drug injection and more likely to increase HIV risk behaviors. People using intravenous drugs were more likely to share needles as a means of avoiding incarceration for being caught, by law enforcement, with drug paraphernalia (Friedman et al., 2006).

Friedman and colleague’s (2007) study findings continue to describe how larger scale forces can set the conditions that lead to disproportionate HIV/AIDS rates. In one example, the gentrification of a Brooklyn neighborhood led to a mass widespread migration of people using intravenous drugs to a Black, African American and Latina/o Brooklyn neighborhood with high rates of unemployment. As the gentrification-induced migration continued, residents of this latter community began to experience a rise in drug-related violence, punitive law enforcement and HIV/AIDS rates (2007). Friedman and colleagues (2007) concluded that such problems are not present to the same degree in middle-class White/Euro-American areas of Brooklyn. These findings illustrate the ways in which individual-level decision making is a direct response to structural-level policies that form imbedded environmental constraints at the micro and
Political factors, social and policy-based zoning, disproportionate rates of incarceration and living in or close to poverty continue to be identified in low-income communities of color as drivers of HIV/AIDS infection that are related to higher-order social structures (Wheeler et al., 2010; Fullilove, 2006; Mullings, 2005; Marin, 2003). An empirical base linking macro-level factors to increased prevalence of HIV risk among Black and African American communities is growing (Bowleg & Raj, 2012; Auerbach et al., 2011). Pilowsky et al (2007), Castor et al (2010) and Arp’s III (2004) findings indicate the limited reach of individually-based methods of HIV/AIDS prevention in communities of color. Studies identify a possible and plausible association between a system of privatized mass incarceration, criminalizing justice and pandemic HIV/AIDS rates among Black, African American and Latina/o communities (Friedman et al., 2006; Belenko et al., 2005).

Research also illustrates the significant role of housing in increasing or constraining proximity to HIV risk-behaviors (Kipke et al., 2007; Pilowsky et al., 2007; Wenzel et al., 2007). Research participants have described how the same behaviors that place them at risk for HIV/AIDS have also been the same behaviors that assist them in staying clear of being criminalized by government programs (Medina, 2009) and surviving living in poverty (Berger, 2004).
CHAPTER VI: THEORETICAL UNDERPINNINGS AND FRAMEWORKS OF THE PROBLEM

This chapter outlines, defines and describes the theoretical underpinnings and frameworks of disproportionate rates of HIV/AIDS among Black, African American and Latina/o communities living in or close to poverty. Power Elite, Marco-Social and Intersectionality theories are offered as theoretical frameworks to making sense of a possible relationship between structural-level drivers of disproportionate rates of HIV/AIDS infections among communities of color. A trajectory of the evolution of HIV prevention models is discussed within these contexts, highlighting the relationship of the research to the social work field.

Power Elite Theory and HIV Prevalence in Communities of Color

Power Elite Theory states that a relatively small group of people control a disproportionate amount of wealth and political power (Dye, 2002; Mills, 2000). When applied to the US, power elite theory identifies that this small group of people is comprised of the executives of the largest corporations, highest ranking military and banking officials, and the president of the US and his cabinet (Dye, 2002; Domhoff, 2000; Mills, 2000). Members of this power elite occupy the most influential positions in the US. They are concentrated among the top positions within financial institutions, governing circles, media moguls and civic establishments (Dye, 2002). These strategic positions carry the authority to direct all of the programs and activities of these influential institutions (Klein, 2007).

Power elite theory asserts that this single elite is comprised of an array of members of smaller communities and decides what the most important issues in the US are. Members of this elite and the programs that they control then package how these issues are presented in the media.
and to the world (Klein, 2007; Spring, 2002; Domhoff, 2000). The purpose of this elite is to create an atmosphere that is favorable to the ideals of its members, including but not limited to “disaster capitalism” (Klein, 2007 p. 211). The beliefs of the power elite are representative of conservative and liberal constructs of the priorities of the US, the role of government and the influence of business (Klein, 2007; Dye, 2002; Domhoff, 2000; Mills, 2000). Although members of this elite community are generally in full agreement in their shared set of core values and beliefs of the world, they frequently disagree amongst themselves on several topics and approaches. However, Domhoff (2000) posits that their shared world view prevents potentially divisive schisms from taking shape within the group.

Power elite theory interprets HIV/AIDS prevalence in Black, African American and Latina/o communities as an outcome of neo-liberal social welfare and crime policies in the US that continue to place communities of color in closer proximity to contracting HIV, such as areas that have or are continuing to experience social disintegration (Wallace, 1993). The expansion of neo-liberal policies has functioned to maintain a status quo through institutions of race, gender and class-based oppression. Shulz and Mullings (2006) assert that HIV rates among Black, African American and Latina/o bodies are the biological manifestation of historic and current marginalizing from access to resources via institutional policies. HIV risk behaviors often occur within the context of resource negotiation, such as exchanging sex for shelter or protection and sharing needles during the process of self-medication. Social welfare, housing and incarceration policies can constrain or maximize micro-level options (Wheeler et al., 2010; Patterson & Keefe, 2008).

These policies were and continue to be constructed by established organizations where members of the power elite occupy the top positions (Dye, 2002). Examples of these policies
include the privatization of prisons (Alexander, 2010) and aggressive cuts in public assistance under the Reagan Administration (Abramovitz, 1992), Bush senior and Clinton administrations (Abramovitz & Morgen, 2006; Roberts, 1997), and the consistent decline of affordable housing from the 1980s through to the 2000s (National Coalition for the Homeless, 2009; Klein, 2007). All of these policies worked in synergy to further disenfranchise and vilify families living close to, at or below the poverty line. These families continue to be disproportionately Black, African American and Latina/o.

Black African American and Latina/o communities comprised 68% of the new HIV infections in 2012, indicating that this public health crisis has reached catastrophic proportions (CDC, 2014b). The cataclysmic rates of HIV in these communities is juxtaposed against their historic and present marginalization from formal access to socio-economic and political power. These factors effectively lock Black, African American and Latina/o people most affected by HIV/AIDS out of naming the problem or co-creating its solution (Alexander, 2010; Freire, 2000). Thus, Black, African American and Latina/o communities are in the ideal position to be constructed as the target group and consumer base for policy (Klein, 2007; Roberts, 1997; Schneider & Ingram, 1993; Rodney, 1972).

Despite the funding that has been released for HIV prevention, the programs that these policies have created have not drastically decreased HIV/AIDS prevalence in the communities hardest hit by this pandemic (Wheeler et al., 2010). Black, African Americans and Latina/o bodies continue to be needed as the consumer base for individually-focused HIV prevention strategies. Simultaneously, their bodies are kneaded by macro-level factors that funnel them into for-profit agencies and institutions, such as jails and prisons. The only other institution in the US
that rivals the punishment industry in profiting from the bodies of Blacks and African Americans is slavery (Alexander, 2010).

Research findings that suggest a predictive relationship between sex-risk behavior and episodes of homelessness, incarceration and living in poverty among research participants from areas that are continuing to experience social disintegration (Wallace, 1993) will illustrate that the power elite-backed social welfare policies have functioned to create and maintain disproportionate HIV/AIDS rates among communities of color. Wallace (1993) has described social disintegration in communities of color as the footprint of neo-liberal policies of criminalizing injustice, declining opportunities for affordable housing, and fewer legitimate employment options in communities living on the margins. The power elite create the conditions for population health (HIV/AIDS rates in communities of color), inter-generational poverty (communities of color having a historicity of living in or close to poverty in the US) and forced migration (disproportionate incarceration among communities of color) through its access to the world’s wealth and its inequitable distribution these resources.

Macro-social Theory and HIV Prevalence in Communities of Color

Macro-social Theory identifies that global-level factors inform national-level factors, which then inform community-level factors (Floery, Galea, & Wison, 2007). Floery and colleagues (2007) posit that global-level factors are representative of multiple tiers that work synergistically to determine population health. These tiers include international trade, how income is distributed among nation-states of the world, patterns of migration and population movement (Floery et al., 2007). According to this conceptualization, global-level factors inform national-level determinants of public health. Social policies, employment, and population density are national-level factors that are informed by where a country or nation-state is stratified
within a web of global-level relationships (Floery et al., 2007). National-level factors then function to inform how resources are allocated, what, where and how social services exist and which options are supported or constrained by physical and social environments (Floery et al., 2007). Although this relationship is often depicted as hierarchical, these associations can be multi-directional. DuBois (2003), Fanon (1967) and Myrdal (2009) have been three of the pioneers to apply macro-social theory to their observations of population health among Black, African, African American, and oppressed communities in the US.

Macro-social theory was initially utilized as a means of sense-making of mortality and disease distribution, during the formative stages of epidemiology as a discipline (Krieger, 2001). During the 20th century, epidemiology employed a more individual focus. The concept that a single and individual risk factor led to a deterioration in population health simultaneously gained in popularity (Honjo, 2004). This shift in epidemiologic focus from structural determinants of population health facilitated the transition in perspective to that of disease caused by exposure to multiple individual risk factors in a “web of causation” (Honjo, 2004 p. 194). The expansion of modern epidemiology overshadowed the macro-social roots of this discipline (Honjo, 2004) with its subsequent focus on individual risk factors. More recently however, (Phelan, Link & Tehranifar, 2010) epidemiology and public health, including the CDC, acknowledge the importance of a social determinants approach to HIV prevention and treatment. Macro-social theory has made a resurgence in the last 20 years as researchers and politicians apply classic questions to new pathogens (Floery et al., 2007; Krieger, 2001).

Applied to the US, macro-social theory identifies the position of the US as one of the richest and most influential countries in the world, despite having lost some of its dominance in global markets post-WWII (Klein, 2007). The current and ongoing marginalized status of Black,
African American and Latina/o populations within the US is the footprint of, if not the deliberate outcome of three key factors. First, the role of the US in the world market has declined as a super power in global communities. The loss of this strong-hold on international economies has influenced groups that represent the interests of the wealthiest US-based communities to campaign for cuts in taxes and domestic spending on social services. These cuts were and continue to be administered through neo-liberal policies that dismantle race, class and gender accords (MacEwan, 2009; Abramovitz, 1992). Undoing these gains toward equality of outcome and not just of opportunity (Omi & Winant, 1994) has facilitated an increase in inequality, especially among Black, African American and Latina/o communities living close to or in poverty (MacEwan, 2009).

Macro-social theory interprets HIV/AIDS rates in Black, African American, and Latino/a communities as the biological manifestation of community level-barriers to resources that are created and upheld by macro and mezzo-level processes. HIV/AIDS rates in the US are highest in Black, African American and Latina/o communities. These communities are also disproportionately represented among people that are or have been incarcerated, people that are living in poverty or have spent time living in poverty and people that are or have been homeless. Pathways to poverty, incarceration and homelessness expand or contract according to social welfare policies that are in place (MacEwan, 2009; Patterson & Keefe, 2008; Floery, et al, 2007; Igushi, et al, 2005; Abramovitz, 1992). Experts identify that social and tax policies have the power to redistribute societal resources equitably among communities (Patterson & Keefe, 2008; Abramovitz, 2006).

The equitable distribution of health care, political power, quality educational opportunities and affordable housing serve as buffers that protect population health (Snowden,
The de-privatizing of governmental responsibilities removes the profit incentives tied to incarcerating human beings (Davis, 1999). These social, economic and political changes function as a pathway for unequal exposure to HIV/AIDS (Patterson & Keefe, 2008). As these pathways increase, buffers that enable population health care and community well-being decrease (Floery et al., 2007; DuBois, 2003). Macro-social theory further posits that if policies can be used to funnel malady-buffering resources out of marginalized communities, policies can then be used to funnel these resources back into marginalized communities and increase public health (Floery et al., 2007).

Study findings that suggest that episodes of unprotected sex are predicted by episodes of homelessness, incarceration and living in poverty will illustrate a direct, although not causal, link between the macro-level factors and individual-level sex-risk behavior. Macro-social theory explains how global-level factors that are outside of the immediate reach of individuals on a micro-level determine what options are and are not accessible in the day-to-day trials and triumphs of individuals. Communities that are in the footprint of billion-dollar industries such as the prison-industrial complex, and its predecessor: slavery are provided with very few, if any, formal pathways to other destinations. These power-elite formed global-level factors stratify communities into intersectional categories that are mutually constituted, interconnected, co-constructed and without biological significance.

**Intersectionality Theory and HIV Prevalence in Communities of Color**

Intersectionality theory posits that the categories of class, gender and race are mutually constituted, interconnected and constructed. These groupings are produced and maintained by the forces of history, political economy and power (Shulz & Mullings, 2006). The constructions of race, class and gender are not stagnant, but instead, reified in macro, mezzo and micro-level
relationships. Mullings (1997) and Collins (1998) add that these classifications are themselves raced, gendered and classed in their production and maintenance. When applied individually, these categories do not adequately capture how they shift as a function of and in relationship with each other (The Combahee River Collective, 2009). Schulz and Mullings (2006) identify that these classifications produce varied outcomes among and within groups. Interpreting forms of oppression as functioning independently of each other distorts the understanding of how they collude and uphold power relationships together. Class, race and gender continue to be regarded by social scientists as an individual characteristic (Wilson, 1997), thus race continues to be identified as a social condition that people with brown and black skin tones have that White/Euro-Americans do not (Schulz & Mullings, 2006). Racism is interpreted as a problem that people of color encounter that is unrelated to the construction of Whiteness (Rothenberg, 2011).

Intersectionality theory posits that interpreting HIV/AIDS infections as a health pandemic that predominantly affects Black, African American and Latina/o communities negates the prevalence of this infection among families living close to, at or below the poverty line. Consequently, reducing HIV/AIDS to being the result of a viral infection that specifically affects communities living close to, at or below the poverty line ignores the fact that men that have sex with men are on the front-lines of loved ones who are disproportionately contracting this preventable infection. Solely focusing on the communities, families and individuals of men that have sex with men as a group that is at the highest risk for contracting HIV/AIDS can homogenize the diversity present within this group. Utilizing class, race or gender by itself inevitably ignores how power informs the contexts of these relationships through the interlocking
of these oppressions and maintains the silence of how constructs of Whiteness continue to inform the distribution of HIV/AIDS rates in the US.

Applied to the US, intersectionality theory posits that the unequal distribution of poverty, incarceration and HIV/AIDS infections are attributable to the stratification of the lives of women, children and men by the constructions of gender, race and class-based oppressions. These constructions are enmeshed in the fabric of the US, from its conception to present. Schulz and Mullings (2006) add that these constructions are produced, maintained and promulgated by structural, institutional and interpersonal oppressions. Structural oppression operates at the macro level of society and functions to privilege some groups, while simultaneously denying access to societal resources to groups that are othered.

Institutional oppression operates at the mezzo level of societal infrastructure and pervades organizational structures, agencies and community-based institutions (Schulz & Mullings, 2006). Interpersonal Oppression takes place at a personal level and informs how individuals make sense of who and how people belong and do not belong (Schulz & Mullings, 2006). Therefore, intersectionality theory interprets HIV/AIDS rates in the US as the biological outcome of historic and contemporary relationships to power. Inherent in these relationships are the constructions of gender norms, race as a biological concept that informs physical abilities and economic stratification of wealth and poverty.

Accordingly, Black, African American and Latina/o communities living closest to, at or under the poverty line are stratified to being in greatest proximity to contracting HIV/AIDS. Conversely, middle to upper class heterosexual able-bodied White/Euro-American communities are illusively positioned the farthest from this pandemic, although they are no less biologically susceptible. Intersectionality theory posits that narrowing down the experiences of a person or a
community to one of the categories of race, class or gender reduces the phenomena in question and distorts the sense-making of the observer. However, reducing HIV/AIDS rates to the lens of race, class and gender can have the same effect if only the experiences of the communities that are marginalized by these relationships are interrogated – producing a sense-making that Blacks have race and Whites do not. The status quos that are centralized and stratified closer to formal power must be understood as being inextricably yoked to the othering of marginalized families and individuals. Concomitantly, social scientists must also explore the ways that these constructs operate to privilege while simultaneously oppressing communities (Coles, 1977). Although HIV/AIDS rates are highest in communities of color living closest to the poverty line, Wallace (1994) illustrates that these infections will eventually travel to the general population.

The sample for the dataset that will be used for this study consists of individuals of various racial ethnicities, sexual-identities and sexual practices from Harlem and the South Bronx. Research findings that suggest that episodes of homelessness, incarceration and living in poverty are predictively associated with HIV sex-risk behavior among this diverse group of Black and Latina/o respondents will also underscore that sex-risk behavior is not limited to specific groups of individuals based on the constructs of sexual-identity or gender. Such findings will illustrate the intersectional complexities in how the categories of sexual-identity, gender and racial ethnicity overlap and are inter-connected, as opposed to mutually exclusive. An example of these categories overlapping could be that both heterosexual women and heterosexual men have engaged in anal intercourse with male sex-partners. Second, I will also interpret this relationship as illustrating the phenomenon of a pathological sense of Whiteness (Rothenberg, 2011) that is working through institutions to stratify communities of color in closer
proximity to HIV/AIDS infections as a means of stratifying White/Euro-American communities in greater distance from this pandemic.

A pathological sense of Whiteness refers to the beliefs that interpret communities with lower rates of HIV/AIDS as being less susceptible, than communities with disproportionate rates of this infection. Power elite circles have orchestrated global-level factors that intersectionally stratify individuals in proximity to and in distance from naming the causes of HIV/AIDS disproportionality among communities of color. The evolution of models of HIV prevention reflect these pathological practices.

**The Evolution of Models of HIV Prevention**

Approaches to HIV/AIDS prevention in Black African American and Latina/o communities in the US can generally be traced back to five theories of behavioral change. These theories include the health belief model, the AIDS risk-reduction model, stages of change model, theory of reasoned action and social cognitive theory (Denison, 2002; Bandura, 2001; Valdiserri, West, Moore, Darrow & Hinman, 1992). Each theoretical approach offers important contributions to the prevention process while attempting to explain and predict human behavior. However, all of these approaches are focused on high risk behavioral change at the individual level with no inclusion of the structural-level factors that constrain or expand individual-level options.

The health belief model (Becker, 1974) posits that behavioral change takes place when individuals perceive a threat to their wellbeing or feel a sense of severity created by their actions. This model adds that when people have clear options of action and feel a sense of self-efficacy, behavioral change occurs (Denison, 2002). Similarly, cognitive/decision-making theory, which is a derivative of the health belief model adds that new information about risky behaviors can
influence behavioral change. A strength of these approaches is that they identify the central role of individuals having access to outlined modes of preventative action as a means of changing their behavior. Wheeler and colleagues (2010) have affirmed the importance of individual and community-level access to female and male condoms, HIV testing and medical care for people living with seropositive status. However, neither of these theories account for structural factors and how these factors can constrain individual-level access to and use of condoms as a means of prevention. Researchers continue to identify that access to condoms does very little if negotiating the use of a condom can result in a harmful outcome for the individual, their wellbeing, the wellbeing of loved ones or an increased prison or jail sentence (Auerbach et al., 2011; Wheeler et al., 2010; Cisneros, 2007; Blakenship et al., 2005).

The theory of reasoned action (Fishbein, 1990) posits that individuals are rational, thus risky behaviors are under volitional control (Denison, 2002). This theory adds that individuals are agents in the process of behavioral change and navigating their environments. According to the theory of reasoned action, an individual’s behavioral and normative beliefs will ultimately inform the individual’s actual behavior. This theory describes this process as linear. The theory of reasoned action affirms the social work tenet of a strengths-perspective by positing that individuals have agency in their choice-making and are capable of making rational decisions (Hopps & Pinderhughes, 1999). However, similar to the health belief model, the theory of reasoned action does not take into account the structural forces that can impede on micro-level choice making. In addition, this theory does not include the context of the participant or their social network (Castor et al., 2010). Social cognitive theory (Bandura, 2001) attempts to address these limitations by adding that the inclusion of the individual’s social network can strengthen approaches to behavioral change. Although social cognitive theory advocates for the recognition
of socio-cultural variables in how information of HIV/AIDS prevention methods is conveyed, like its predecessors, it does not speak to how macro-level policies can influence microlevel access and behaviors.

*Stages of change theory* (Prochaska, DiClemente & Norcross, 1992) is used to identify the processes that are both present and necessary in sustainable behavioral change in favor of HIV prevention. According to this theory, behavioral change consists of five stages (Denison, 2002). These stages range from pre-contemplation, where the individual is described as having a problem whether or not s/he recognizes it, to the final stage where the individual has changed the behavior and maintains the new behavior. A strength of this approach is that it attempts to delineate the process for and isolates which behavioral change occurs, interpreting the individual as the central agent in this shift (Denison, 2002). Like the theories discussed above, stages of change theory neither critiques nor mentions the role of structural-level factors in the context of the behavior or the process of changing the behavior. Stages of change theory is geared towards the internal processes of individual behavioral transformation (Denison, 2002). Similarly, the AIDS risk reduction model shares the same focus and adds that a plan of action to reduce the risk of HIV infection can help to facilitate the occurrence of behavioral change (Denison, 2002).

Both approaches are individually-based and do not speak to the presence of structural-level factors in micro-level exchanges. The AIDS risk reduction model and the stages of change theory specifically identify individual-level behaviors as problematic. Similar to social cognitive theory, social learning theory adds that the recognition of the influence of social cultural variables can support the process of behavioral change. Reflective of the health belief model and both of the stage-oriented models, social learning theory incorporates the use of information and skills-building as a means of equipping individuals to choose methods of HIV/AIDS prevention.
Although each of these theories contributes to HIV/AIDS prevention approaches, they also indicate the limitation of being too narrowly focused on individual behavioral change (Wheeler et al., 2010).

Utilizing an individual focus towards behavioral change without identifying the need for macro-level change problematizes and scapegoats’ individuals and communities. Such an approach neglects to hold social policies accountable for how they are used to ration societal resources and access to formal power structures (Wheeler et al., 2010; Schulz & Mullings, 2006; Titmuss, 1979). Making sense of HIV/AIDS prevalence solely through a lens of individual-level risk behaviors as the pathway of infection distorts the understanding of this health pandemic. Focusing solely on the individual as the central agent in the changing of risk behaviors essentializes the complex social, political and economic systems within which they are embedded. Although these theories advocate that the individual is a source of rational choices and power (Bandura, 2001), they do so at the cost of not including how the contexts which the individual is immersed in, inform and constrain this power (Wheeler et al., 2010).

Individual-level change is integral to methods of HIV/AIDS prevention (Green & Rurak, 2011). However, condoms cannot hold accountable macro-level policies of resource-distribution and the forced migration (Wallace, 1990) that disproportionate incarceration imposes. Relying solely on individual-level change as a means of HIV/AIDS prevention does not address the risky systems that necessitate and inform risky behavior (Wheeler et al., 2010). This approach interprets the individual as existing within a vacuum, simultaneously stripping individuals of the context within which they are living. Schulz and Mullings (2006) further identify that an individually-based approach also ignores the historicity and contemporary relationship between the individual and the actualization of the US through its social policies.
An individual approach stripped of the context of macro-level factors permits HIV/AIDS to be understood as a problem within, among and limited to particular individuals. Instead of HIV/AIDS being made sense of and promoted as a health pandemic that affects everyone with its potential to infect anyone, the virus is understood as the result of poor or deviant lifestyle choices among a select few (Washington, 2006). When this approach is coupled with the skills and awareness components of most HIV/AIDS prevention models, individuals are likely to be interpreted as being uninformed about how to use condoms, how to engage in monogamist relationships and not to share needles. All these attitudes interpret the outcome of at-risk behaviors as stemming from a lack within the individual as opposed to the behavior having been informed by the context that the individual is situated within (Wheeler et al., 2010).

Identifying communities that are described by social scientists as being more at-risk than others, coupled with the sense-making of an individually-focused approach towards behavioral change can further undermine HIV/AIDS prevention efforts. The combining of these perspectives has been utilized to lend credulity to biological explanations of the distribution of HIV/AIDS infections (Schulz & Mullings, 2006; Chirimuuta & Chirimuuta, 1987). Schulz and Mullings (2006) add that these explanations reify false concepts of race as a biological truth, while merely substituting the notion of culture for race. Biological, lifestyle and culture-based explanations continue to identify the individuals or communities of the target group as the source of the cause of the health disparity rather than unequal social relations or ineffective interventions (Schulz & Mullings, 2006; Marshall, 2004). Instead of seeing only individuals as lacking, the coupling of these two concepts interprets entire communities, if not races and ethnicities, as culturally deficient. Stanley Lieberson’s (1980) study findings that indicate that although cultural deficiency or lack of a assimilation have been offered by scholars as
explanations of the marginalized status of Blacks and African Americans in the US, none of these explanations are tenable when the effect of social policy and institutionalized prejudice have been examined. According to the messages in the news media about HIV/AIDS, this infection in addition to race (Schulz & Mullings, 2006), continues to be something that Black, African Americans and Latinas/os have, that White/Euro-Americans do not (Fumento, 1990).

Currently, HIV prevention in the US is focused on increasing the use of condoms, testing for the viral antibody, and encouraging the use of PrEP for prevention and ART for both prevention and treatment. HIV and AIDS are simultaneously promoted as a “black disease” in the news media, posters and campaigns to inspire people to know their status (Washington, 2006 p. 332). Promoting that HIV can be prevented by using condoms, while it is simultaneously promoted as a black disease reinforces race as a biological trait that informs behavioral practices (Schulz & Mullings, 2006; Marshall, 2005; Fanon, 1967). Thus, the message conveyed is to inform people of color to take responsibility for their sexual exhibitions. This message omits addressing societal-level factors that marginalize these communities into being at a disproportionate risk for HIV infection.

The message conveyed and the images used to offer a visual of HIV/AIDS reinforces the use of damage imagery in depicting people with black and brown skin tones in the US (Scott, 1997). The use of an individual approach to behavioral change in addition to identifying that some communities are more likely to contract HIV/AIDS than others enables communities who consider themselves to be outside of these groups to feel a dangerous and false sense of immunity. The illusion of immunity is inextricably yoked to the illusion of biological susceptibility, which in and of itself is made possible through a narrow lens of individual-based methods of behavioral change.
CHAPTER VII: METHODOLOGY

Research Design

This chapter describes the methods used to conduct the dissertation study, provide an overview and design of the original study from which the data used in this dissertation was derived from, describe the variables selected from the original study for the purposes of the dissertation, and the strategies followed in analyzing the data. This dissertation sought to explore the relationship between structural macro-level factors such as income, incarceration and homelessness, and HIV risk behavior. Baseline data from a randomized controlled trial that tested a safer-sex HIV prevention intervention among drug users in Harlem and the South Bronx was used to assess the influence of these structural factors on individual level decisions made regarding safer sex, and HIV infection risk. Through the use of secondary data analysis, this dissertation was able to answer the research question: Do structural factors predispose Blacks, African Americans and Latinos/as to engaging in HIV risk behaviors.

Description of Larger Study Used for Secondary Analysis

This study employed secondary data analysis of data collected for a NIDA-funded randomized controlled trial. The purpose of that study was to test the efficacy of a four-session, cognitive-behavioral skills-building HIV prevention intervention with non-injection drug users and their network members (Pilowsky, Hoover, Hadden, Fuller, Hoepner, de Leon, et al., 2002). The baseline data from this original study was used to assess the relationship between macro-level structural factors and micro-level individual sex risk behaviors which put drug users living in Central and East Harlem and the South Bronx, at risk for HIV infection.

In the original study, research participants were assessed at pre-intervention, and at three, six, nine and 12 months post-intervention. Pilowsky and Hadden were co-principal
investigators on this study. They gave me approval for use of the baseline data used in this dissertation. The goal of Pilowsky and colleagues’ (2007) research was to assess the efficacy of an intervention to lower sexually risky behavior among non-injection drug users aged 18 to 30 years in Harlem and the South Bronx (Castor et al., 2010). The researchers recruited 112 non-injection drug users and 152 drug users and/or sexual partners to participate in a two-tiered randomized control prevention trial. Study participants were randomly assigned to either the control or experimental condition (Pilowsky, Hadden et al., 2002). A graphic model of the study design is located in the appendix.

**Participant Recruitment for the Original Study**

Potential research participants were street-recruited by research staff working in pairs. Prior to conducting the recruitment, the Harlem and south Bronx areas were mapped to identify the hanging-out areas of street drug users. Following the drug-use area mapping, paired recruiters (often male and female) approached individuals at these mapped sites and following introduction of themselves, described the study and invited individuals to participate in the study. Recruiters distributed attractively designed contact cards to interested potential participants and encouraged them to contact the study researchers. If anyone expressed an interest in participating right away, they returned to the study site with the recruiters where they were introduced to the research personnel who described the study in more detail and answered any questions that potential participants had. Interested participants then completed a 10-minute face-to-face screening interview to establish whether they met the study eligibility criteria.

**Screening Criteria**

Separate criteria existed for index and network partners. Index participants had to be: between the ages of 18-30, HIV negative, using illicit drugs but never having injected drugs,
sexually active and have up to three drug/sex partners (called social network partners) who would participate in the study. Network partners had to be: at least 18 years old, invited by an index participant, and identified as a sex/drug using partner of the index participant. All potential index study participants were tested for HIV status. Those who tested HIV positive were referred immediately for HIV treatment. All potential participants who met study criteria were then invited to an interview in which they would provide informed consent for study participation and complete a baseline interview.

**Informed Consent, Certificate of Confidentiality and Assessment Instruments**

The informed consent, Certificate of Confidentiality and baseline interview were administered by a trained interviewer at the study site, either immediately following the screening interview or at a mutually agreed-upon date and time. Prior to the administration of the baseline interview, research personnel obtained signed informed consent from study participants and described the protections provided by the Certificate of Confidentiality obtained from the National Institutes of Health. The Certificate protected identifiable participant information from forced disclosure in civil, criminal, legislative, administrative or other proceedings whether at the local, state or national level. The baseline interview comprised a battery of assessment instruments including demographic questions, alcohol and drug use, a personal network inventory, sexual risk behaviors and the Center for Epidemiologic Studies Depression Scale (the CES-D).

Interviews lasted approximately two hours and provided high completion rates. Participants were provided with healthy snacks during the interview, could take as many breaks as needed and child-care was provided for people who came to the interview with children. Both index and network participants completed the same instruments. Upon completion of the
baseline interview, participants were invited to return for the first group session of the randomized controlled trial.

**Randomization**

Two hundred and seventy participants who completed the informed consent and baseline interview were invited to attend four, weekly-held, 90-minute facilitated group sessions delivered in 13 cycles at the study sites. On the first day of each cycle, all invited cycle participants were randomly assigned to a treatment or control group using stratified-block randomization, resulting in two experimental groups (one female and another one male) and two control groups (one female and another one male) per cycle. Index and network participants were assigned to the same condition to make sure that they were exposed to the same knowledge and skills that were learned in the groups.

**The Group Intervention**

The randomized control trial tested an HIV prevention intervention which offered cognitive, behavioral and skills-building information via discussion and role-play that was aimed at changing individual-level and group-level sex risk behavior. Study participants were randomly assigned to either an experimental or a control group, with index participants being in the same assigned condition as their sexual/drug network partner(s). Participants in the experimental group were exposed to an intervention that combined social influencing approaches with cognitive, behavioral and skills-building aimed at sex risk reduction. The control group was exposed to videotapes that focused on health-related topics. The format for group administration was similar for both the experimental and control conditions. Participants in both groups met in gender-separate groups facilitated by gender-similar group leaders for the first 45 minutes and then came together in a combined group facilitated by two group leaders. This format was
consistently applied through all the four sessions for the 13 cycles (Pilowsky, Hadden, et al., 2002). The study included four follow-up assessments at three, six, nine and 12 months after exposure to the control and experimental conditions.

Gathering information about structural factors was not the said purpose of the study. However, Pilowsky and colleagues (2007) collected quantitative data on each of the participants’ means of income, and experiences with homelessness and incarceration history among a myriad other questions related to sex-risk behavior and HIV infection. Pulling from this dataset, I have used all the data gathered in the baseline interviews that describe or refer to these structural factors (Please see the Data Extraction Sheet enclosed in the Appendix). I did not examine the pre and post-test status of structural factors.

**Reliability and Validity**

Pilowsky, Hadden and colleagues (2002) enhanced the rigor of their research by utilizing assessment tools with high reliability and validity. The assessment tools used had been repeatedly tested and extensively used in prior studies. To minimize threats to the validity of the findings, study data were entered using logic checks to ensure quality of data entry. In addition, interviews were administered by trained research staff, and errors in data entry were minimized and participants were able to ask questions and clarify questions they did not understand. Measurement error was minimized in this way.

Throughout the research process, research staff responsible for retention and follow-up, were distinct from staff that provided the intervention. Pilowsky, Hadden and colleagues worked to avoid chronologically concurrent cycles from occurring. However, when this was not avoidable, the groups were scheduled on different days of the week. This arrangement minimized the possibility of research contamination through groups interacting with one another.
The precautions and statistical analyses that Castro, Pilowsky, Hadden and colleagues (2007) have taken to ensure for reliability and validity have produced a dataset of superior empirical quality. A challenge in using this data was the necessity to become familiar with complex and dense research tools/assessments and best-fit multivariate statistical analyses in a relatively short amount of time.

Dissertation-specific Methodology

Pilowsky, Hadden and colleagues’ (2007) research study was approved by the Institutional Review Boards of the New York State Psychiatric Institute, Columbia University, and the New York Academy of Medicine. Permission was obtained from Dr. Bernadette Hadden and Dr. Daniel Pilowsky; the Primary Investigators of the original research to use a subset of the baseline data for this dissertation and The New York State Psychiatric Institute granted approval for the re-opening of the original data for analysis. Exempt approval was obtained from the City University of New York’s Institutional Review Board for the use of this dataset, as required for dissertation research purposes.

The study sample for the randomized controlled trial comprised a total of 270 index (n=100) and network members (n=170). Using secondary data analysis, I have analyzed the baseline data to investigate the relationship between structural-level contexts and individual-level behaviors through stepwise multiple regression analysis. A dataset with baseline data on all 270 study participants offered me the best opportunity for analyzing a sufficiently robust dataset with demographic and sex-risk behavior variables.

Assessment of Sex Risk Behavior

The focus of this dissertation research is on the relationship between structural macro-level factors including poverty, homelessness and incarceration and individual-level sex-risk
behaviors of participants. Poverty was operationalized by participant income, homelessness was operationalized by a question which asked how many times respondents had ever been homeless, incarceration was operationalized by a question which asked how many times a respondent had ever been in jail, prison and/or juvenile detention, and sex-risk behavior was measured by the Vaginal Episode Equivalent (VEE). The VEE is a weighted index of each episode of unprotected oral, vaginal and anal intercourse (Susser, Desvarieux, & Wittkowski, 1998). Each episode of unprotected sex is assigned a risk score of 2.0 for anal, 1.0 for vaginal and 0.1 for oral sex (Castor et al., 2010). This weighting is based on the findings of previous studies that anal sex is at least twice as risky as vaginal intercourse (Roye, Tolman & Snowden, 2013; Susser, Desvarieux, & Witkowski, 1998). The VEE is calculated by tabulating each study participant’s cumulative oral, anal and vaginal unprotected sex episodes and converting them to a VEE score as the sum of all VEE points. Labelling the episodes of anal, vaginal and oral sex as VEE is not meant to reify the heteronormative primacy of vaginal sex (Castor et al., 2010), but simply to put risk associated with each type of unprotected sex into perspective.

**Data Analysis Strategy**

The variables I selected for analysis from the existing data set referred to structural forces that I propose may be associated with engaging in high-risk behavior for HIV infection. (Abu-Bader, 2006; Mertler & Vanatta, 2013; Norusis, 2014). I started out by developing a data extraction sheet to isolate the variables of interest for this dissertation from the original study by Pilowsky, Hadden and colleagues. The variables include: list them as questions in the questionnaire.

I then familiarized myself with the codebook for the original dataset, to identify the variables of interest in the original SPSS data. Next, I ran frequencies on all variables of interest
to clean the data. Decisions were made regarding missing data and outliers. Where data were missing for 5-15% of the sample, those variables were not included in the analysis. Where outliers created markedly skewed distributions, data were transformed and recoded to create more normal distributions. Univariate analyses were performed as the first stage of analysis to provide descriptive findings for the study. Thereafter, bivariate analyses were performed to assess the relationship between macro-level factors and individual sex-risk behaviors. Finally, stepwise multiple regression models were used to assess the effect size of the relationship between these macro-level structural factors and sexual risk behavior. Stepwise multiple regression models enabled me to predict the effect of multiple conditions such as homelessness, poverty and incarceration (Abu-Bader, 2006) on a single outcome of engaging in HIV sexual risk behavior (expressed as the total of unprotected oral, vaginal and anal sex episodes in the past 3 months).

Assessing whether or not these structural forces predisposed the participants to engaging in sexual risk behaviors can inform social work HIV/AIDS interventions if focusing on the primary prevention of poverty, homelessness and incarceration might be more useful for thwarting this public health pandemic. Findings that indicate that the independent variables of macro-level forces predict the criterion variable of HIV sexual risk behavior offer strong support for greater focus on primary prevention that addresses these pathogenic pathways of HIV/AIDS (Albee et al., 1988; Joffe & Albee, 1979) as a means of making the individual-level methods of prevention, such as condom use, more accessible (Green & Ruark, 2011; Wheeler et al., 2010).
Data Management

The data used for the dissertation are saved in password protected files on the hard drive of my laptop. My laptop was protected from information loss or viral attack by Avast Antivirus software, and updated regularly throughout the data analysis period. All data and analyses were backed up on a back-up drive at the end of each workday. When not in use, my laptop was locked in a file cabinet inside my apartment. Data were de-identified prior to my obtaining the dataset from the Principal Investigators of the study.

Human Subjects

The quantitative secondary data analysis did not entail contact or an intervention with human subjects. I was granted permission to utilize the baseline data by Dr. Bernadette Hadden and Dr. Daniel Pilowsky, and the data were used with a de-identifying coding system already in place. This system insured that the research participants were not identifiable. IRB approval was obtained from the New York State Psychiatric Institute and Hunter College’s Office for Human Research Protection Subjects to re-open and use the original study’s dataset for this dissertation’s data analysis purposes and writing up of study findings.

Data Analysis

The purpose of the data analysis for this study was to examine the relationship between the structural factors of homelessness, poverty, incarceration and HIV sexual risk behavior. The data analysis is comprised of four steps. First, univariate analysis was used to describe the study sample. The gender, age race and ethnicity of the research participants are listed and described. Second, bivariate analysis was utilized to describe the critical variables in the proposed study and tested the relationships between these variables. First I recoded the questions that asked about incarceration, homelessness and income into nominal levels of measurement making the possible
responses to each question mutually exclusive. I then computed a target variable for each theme that added the sum of encounters with each theme. For example, the target variable ‘sumincarceration’ totaled the affirmative responses to the three questions that inquired about a history of incarceration.

This also included creating the Vaginal Episode Equivalent (VEE) by assigning a weighted index of one-tenth of a point to oral sex, one point to vaginal sex and two points to anal sex (Susser, Desvarieux, & Wittkowski, 1998). The purpose of the VEE is to tabulate a score that measures for proximity to HIV sex risk according to the number of unprotected episodes of anal, vaginal or oral sex. Next conducted bivariate analysis using the appropriate statistical tests to identify which relationships were statistically significant and not occurring by chance. These tests included the two-tailed Pearson correlation test, chi-square, one-way ANOVA and independent-samples T-test (Abu-Bader, 2006; Kachigan, 1986).

Abu-Bader (2006) explains that when social work researchers wish to know more than whether two variables are correlated, multivariate statistical analyses are used to predict a specific outcome based on multiple conditions. The strength of utilizing this statistical approach is that it permits the social work researcher to explore the relationships of a wide range of data in a relatively short amount of time. In addition, the researcher is able to ascertain the statistical significance and effect size of the relationships that the model illustrates. A strength of multiple regression analysis is that the social work researcher selects the predictor variables based on practice expertise and knowledge of the literature and previous study findings. When a predictor variable is expressed as a beta coefficient, such as that obtained from the hierarchical linear regression, the effects of the other variables that correlate with the independent and dependent variables which we are investigating are statistically extracted.
(Kachigan, 1991). Since each beta coefficient is in *standardized z* form with the same standard deviation and mean, the absolute values of these “partial regressions” were used to inform me of the hierarchical order of the effect size or importance of the predictor variables in relation to the criterion variable (Kachigan, 1991, p. 183). Despite the brilliance, utility and accuracy of this statistical measurement, beta regression coefficients can only inform social work researchers of the relative importance of predictor variables, not their absolute contributions to the variance of the criterion variable. In addition, the relative effect size of any two predictor variables is contingent on which other independent variables have been included in the analysis.

Incorporating additional, fewer or different independent variables could produce a very different rank in the importance of coefficients (Kachigan, 1991). However, Kachigan (1991) illustrates that it is generally enough for social science researchers to be able to ascertain the rank-ordering of the selected predictor variables in their efficacy in accounting for the variance of a criterion variable. Beta regression coefficients in multiple regression analysis successfully and empirically provide this information.
CHAPTER VIII: RESULTS

This chapter presents the demographics and frequencies for sex behavior. Bivariate relationships and multivariate models with statistical significance are also outlined and presented.

Demographics

Gender, Age, Race and Ethnicity

A total of 270 participants completed the baseline interview of the study. Pilowsky, Hadden and colleagues (2007) listed a sample size of 264 study participants because this number did not include two participants whom had since died of non-study related causes and four transgender individuals whose data were analyzed apart from the larger dataset. Of the 270 study participants, 67% (n=180) were males, 32% (n=86) were females and 4 participants were transgender. Study participants ranged from 18 to 59 years of age, with the average age being 33 and the most frequently occurring age being 35.

Fifty-six percent of the sample (n=152) identified as Black, 5 individuals as Native American, 25 individuals as White and 33% (n=88) people identified as other or being of mixed races and or ethnicities. Forty-three percent (n=117) of the sample identified as Hispanic. The Hispanic ethnicities represented in the study included South American, Cuban, Dominican and Puerto Rican. Twelve study participants identified as being Black and Hispanic/Latino, four identified as being American Indian and Hispanic/Latino, 16 identified as being White and Hispanic/Latino and 85 as being Hispanic/Latino and mixed with an ethnicity or race that was not listed. Table 1, below, illustrates the racial background of the study participants that identified as Hispanic/Latino.
Table 1.

Hispanic/Latino and Racial Background

<table>
<thead>
<tr>
<th>Hispanic/Latino</th>
<th>Black</th>
<th>American Indian</th>
<th>White</th>
<th>Other/Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>140</td>
<td>1</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>4</td>
<td>16</td>
<td>85</td>
</tr>
<tr>
<td>Total (n = 270)</td>
<td>152</td>
<td>5</td>
<td>25</td>
<td>88</td>
</tr>
</tbody>
</table>

Among the 117 respondents who identified as Hispanic/Latino, 85 were of Mixed decent, 16 were White, 12 were Black and 4 were Native American. Of the respondents who identified as Hispanic or Latino, 11 identified as being Black and Hispanic: 7 were Puerto Rican and Black, 2 were South American and Black, 1 was Dominican and Black and 1 identified as ‘other’ and Black. Four people identified as Native American and Hispanic/Latino. Sixteen people identified at White and Hispanic/Latino: 15 were Puerto Rican and White, and one person was Cuban and White. Eighty-Four respondents identified as being of Mixed decent and Hispanic/Latino: 3 people were South American and Mixed, 69 people were Puerto Rican and Mixed, 2 people were Cuban and Mixed, 3 people were Dominican and Mixed, and 7 people identified as ‘other’ and Mixed. Table 2, below, illustrates the race and ethnicity backgrounds for respondents who identified as Hispanic/Latino.
Table 2.

Ethnic Background and Racial Background of Study Participants

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Racial Background</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
</tr>
<tr>
<td>South American</td>
<td>2</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>7</td>
</tr>
<tr>
<td>Cuban</td>
<td>0</td>
</tr>
<tr>
<td>Dominican</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Total: (n = 115)</td>
<td>11</td>
</tr>
</tbody>
</table>

Education and School Enrollment

At the time of the study, 23% (n=61) of the respondents were enrolled in school within the last six months. For ‘Highest Level of Education’ completed, 9 of the study respondents had completed eighth grade or less, 11 study participants had completed college, 16% (n=42) had completed some college, 39% (n=106) had completed some high school and 38% (n=102) participants had completed high school within the prior six months of the study.

Sources of Income/Employment

Study participants were asked about their source of income based on a list of numerous categories that they could select. Respondents selected multiple sources of income. Forty percent (n=107) reported receiving money from a regular job and 50% (n=136) received money from temporary work. Seventy-four percent (n=200) of the study participants received public assistance. When asked if they had received any money from family or friends in the last six months, 80% of the sample replied ‘yes’. Sixteen percent (n=43) reported that they had received money from theft in the six months prior to the study.
When asked if they had received any money from selling drugs, 29% (n=78) replied that they had. When asked about receiving money from sex in the six months prior to the study, 17% (n=45) of the sample replied that they had received money from selling sex. When asked from where they had received most of their income, 57% of the study sample replied from either family and friends or public assistance. Twenty-three percent (n=61) of the study participants reported that they received most of their income from either selling drugs or selling sex and 10 respondents received money from theft. Sixteen percent (n=44) of the study sample received most of their income from a regular job, temporary work or recycling cans.

**Homelessness**

More than half (54%; n=145) of the study participants reported having been homeless in the six-months prior to the study. When asked where they lived most of the time, 36% (n=96) reported that they had lived in a shelter, 22% (n=58) lived in someone’s house and 21% (n=57) lived in their own house. Twenty-three respondents lived in a parent’s house, 12 lived in a rented room and 4 of the respondents lived in an abandoned building. Nine study participants replied that they lived in jail in the six months prior to the study and 7 people had lived in a halfway house. Four study participants replied that they lived in a dwelling that was not listed as a category (i.e. ‘other’). When asked if they had ever lived in a foster home, 22% (n=60) of the study replied ‘yes’. Forty-eight percent (n=130) of the study participants had slept in a car, abandoned building or park six months prior to the study.

**Incarceration**

Seventy-four percent (n=200) of the study participants have been in either jail, prison or detention at one or more points in their life. Most of the study (n=173) participants had been in
either jail, prison or detention multiple times (either ten times or less). The highest number of

times that a study participant (n=5) had been incarcerated or in a detention center was 50-times.

**Sexual Behavior: Female with Male Partner/s.**

The female participants of the study were asked about their sexual practices and current

sex partners during the three months prior to the study. In regard to sexual identity, female

respondents were asked how they think of themselves. Sixty-eight percent (n=60) of the

respondents identified as straight, 19% (n=16) as bisexual, 10 as gay/lesbian, one person

identified in a way that was not listed as a category or ‘other’.

When asked if they had engaged in any vaginal, anal or oral sex with a male partner in

the last three months, 84% (n=71) replied ‘yes’, that they had engaged in sex in the past three

months with a male partner/s. Female study participants were asked how many men they had

had sex with each of the male partners. Sixty-nine percent (n=50) reported having 1 male sex-

partner, 15% (n=11) had 2 male sex-partners, 10% (n=7) had 3 male sex-partners, 3 had 4 male

sex-partners and 1 had 5 male sex-partners. Forty-five (63%) reported having between 1-25

episodes of anal, vaginal and or oral sex in the three months prior to the study with a male

partner/s, 15 reported between 26-61 episodes, 10 reported between 62-100 episodes and 2

reported between 115-180 episodes of vaginal, anal or oral intercourse with their male partner/s.

The average number of oral, vaginal and or anal sex episodes that a female respondent listed was

31.

Female study respondents were then asked to the best of their knowledge, if their male

partners had engaged in sexual intercourse with another sex-partner since the female respondent

and the male partner had become sexually involved. Sixty-five percent (n=39) of the study
respondents reported that their male partner/s did not have any sexual-partners since the time that they had first became sexually involved, 22% (n=13) reported that their male partner had one other sex-partner and 10% (n=6) respondents reported that their partner had 3 other sex-partners. Four participants replied that their male partner/s had had sex with a man within the last three months of the study.

**Vaginal Intercourse: Females with Male Sex-Partner/s**

Female study respondents were asked the number of vaginal sex episodes that they had had in the three months prior to the study. One women listed 0 vaginal sex episodes, 50 women listed between 1-30 episodes, 19 women listed between 40-100 episodes and 2 women listed between 115-180 episodes. The average number of vaginal episodes for the female study respondents was 30. When asked about the total number of episodes of unprotected vaginal sex, 28% (n=24) replied 0, 26% (n=22) replied between 1-9, 22% (n=19) replied between 10-29 and 24% (n=21) replied 30 or more episodes of unprotected vaginal sex.

**Protection Methods for Vaginal Sex: Females with Male Partner/s**

Female study respondents were asked about the protection methods to prevent pregnancy or sexually transmitted diseases that they had used in the last three months. Twenty-five women had used a male condom between 1-25 times in the three months prior to the study. Two respondents reported using a method of protection other than a male or female condom. No female respondents reported using a female condom in the three months prior to the study.

**Reasons for Engaging in Vaginal Sex: Females with Male Partner/s**

The female respondents of the study were asked about their reasons for engaging in vaginal sex with their male sex-partner/s. The categories that a respondent could have selected were: sex for in exchange for money’ or ‘sex in exchange for drugs/alcohol’. Sixteen women
had received money in exchange for sex between 1-18 times and 2 women had received money in exchange for vaginal sex between 25-100 times in the three months prior to the study.

Seventeen women had received drugs or alcohol in exchange for sex between 1-42 times during the three months prior to the study.

**Anal Intercourse, Protection and Reasons: Females with Male Partner/s**

Although anal intercourse was not as frequent as vaginal sex for the female respondents of the study, eighteen women replied that they had engaged in anal sex with their male partner/s between 1-15 times during the three months prior to the study. Eleven (13%) respondents listed having had between 1-4 episodes of unprotected anal sex and 5 reported 5 or more episodes of unprotected anal sex. Three women reported using a male condom between 1-4 times during anal sex in the three months prior to the study, use of a female condom was not reported. Three women respondents reported receiving money in exchange for anal sex between 1-3 times and 3 reported receiving drugs or alcohol between 1-4 times in exchange for anal sex during the three months prior to the study.

**Sexual Behavior: Male with Female Partner/s**

The male participants of the study were asked about their sexual practices and current sex partners during the three months prior to the study. Male respondents were asked how they think of themselves regarding their sexual identity. Ninety-three percent (n=164) male respondents identified as straight, 5 as bisexual, and 8 as gay/lesbian. Seventy-six (n=35) replied that they had engaged in vaginal, anal or oral sex with a female partner in the last three months. When asked how many women they had engaged in vaginal, oral and or anal sex with during this time period and how many times they had had sex with each of their female sex-partner/s, 66% (n=91) listed 1 female sex-partner, 15% (n=21) listed 2 female sex-partners, 13 listed 3 female
sex-partners, 9 listed 4 female sex-partners, 2 listed 5 female sex-partners, 1 listed 6 female sex-partners and 1 respondent listed 7 female sex-partners.

Data was missing for 23% (n=42) of the male respondents. Ninety-four (68%) reported having between 1-31 episodes of anal, vaginal and or oral sex in the three months prior to the study with a female partner/s, 36 reported between 35-90 episodes, 4 reported between 92-153 episodes and 2 reported between 195-252 episodes of vaginal, anal or oral intercourse with their female partner/s. The average number of oral, vaginal and or anal sex episodes with a female sex-partner that a male respondent listed was 29.

Male study respondents were then asked to the best of their knowledge, if their female partners had engaged in sexual intercourse with another male partner since the male respondent and his female partner/s had become sexually involved. Sixty-three percent (n=75) of the study respondents reported that their female partner/s did not have any other male sexual partners, 22% (n=26) reported that their female partner had one other male sex-partner, 2 respondents reported that their female partner had 3 other male sex-partners and 1 reported that his female partner had 5 other male sex-partners since the time that they had first became sexually involved.

**Vaginal Intercourse: Males with Female Sex-Partner/s**

Male study respondents were asked the number of vaginal sex episodes that they had engaged in with their female sex-partners in the three months prior to the study. Thirteen men replied that they had not engaged vaginal sex in the past three months, 87% (n=107) reported between 1-48 episodes, 24 reported between 50-100 episodes and 4 reported between 103-252 episodes of vaginal sex with their female sex-partner/s. The average number of vaginal episodes for the male study respondents was 27. When asked about the total number of episodes of unprotected vaginal sex, 45% (n=81) replied 0, 19% (n=35) replied between 1-9, 17% (n=31)
replied between 10-29 and 18% (n=33) replied 30 or more episodes of unprotected vaginal sex with their female sex-partner/s.

Protection Methods for Vaginal Sex: Male with Female Partner/s

Male study participants were asked about the protection methods to prevent pregnancy or sexually transmitted diseases that they had used in the last three months. Sixty-nine (47%) of the sample used a male condom between 1-40 times and 8 used a male condom between 43-65 times during vaginal sex with their female sex-partner/s. Two respondents reported using a female condom between 1-3 times during vaginal sex in the past three months.

Reasons for Engaging in Vaginal Sex: Males with Female Partner/s

Male respondents of the study were asked about their reasons for engaging in vaginal sex with their male sex-partner/s. Eight men had received money in exchange for vaginal sex between 2-24 times and 11 men had received drugs or alcohol in exchange for sex between 1-44 times in the three months prior to the study.

Anal Intercourse, Protection and Reasons: Males with Female Partner/s

When asked about episodes of anal sex with their female sex-partner/s during the three months prior to the study, 21% (n=32) replied that they had engaged in anal sex between 1-10 times and 10 replied having between 11-36 episodes of anal sex. Nineteen percent (n=34) replied having multiple (1 or more) unprotected anal sex episodes with their female sex-partner/s in the three months prior to the study. Twenty-one respondents reported that they had used a male condom between 1-30 times and one person reported using a female condom 7 times during anal intercourse with his female sex-partner/s. Two men received money from their female sex-partner/s 1 time in exchange for anal sex and 2 men received drugs or alcohol from their female
sex-partner in exchange for anal sex between 3-5 times during the three months prior to the study.

**Sexual Behavior: Male with Male Partners**

**Anal Intercourse Episodes, Protection and Reasons: Male with Male Partner/s**

Of the 180 male study participants, 12 men identified as either bisexual or gay/lesbian and 1 man identified as ‘other’; a sexual identity that was not listed as a category. Thirteen men reported engaging in anal or oral intercourse with a male-sex partner in the preceding three months of the study. Of these respondents, 1 man identified as bisexual and reported no sexual encounters with a male sex-partner and 1 man identified as straight and reported 1 episode of sex with a male sex-partner. Table 3 illustrates how male respondents sexually identified and the number of same-sex encounters that they reported.
<table>
<thead>
<tr>
<th>Total # of Same-Sex Sex Occasions</th>
<th>Straight</th>
<th>Bisexual</th>
<th>Gay/Lesbian</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
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<tr>
<td>12</td>
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<tr>
<td>14</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>25</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>40</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total (n = 14)</td>
<td>1</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

Male respondents were then asked about their number of male sex-partners in the three months before the study. Nine respondents listed 1 male sex-partner, 1 listed 2 male sex-
partners, and 3 listed 3 male sex-partners. When asked how many times they had engaged in anal or oral sex with their male partner/s, 7 replied between 1-10, 5 replied between 11-25 and 1 person replied 40 episodes of sex with their male sex-partner. Male participants were asked how many times they had engaged in anal sex with male sex-partner/s. Eight replied between 1-10 and 4 replied between 11-40 anal sex episodes in the three months prior to the study. Of the respondents, 1 man reported as identifying as bisexual and not having any anal-sex episodes with male sex-partners in the three months preceding the study. The average number of anal sex episodes that a male respondent listed was 1. Nine respondents reported having used a male condom during oral or anal intercourse with their male partner/s between 1-40 times in the past three months. Three men reported exchanging oral or anal sex for money between 3-13 times and 2 men exchanged oral or anal sex for drugs or alcohol between 1-3 times in the past three months prior to the study.

When asked about episodes of insertive anal sex 8 male respondents replied that they had given insertive anal sex during the preceding three months of the study. Seven men reported multiple (2-40) episodes of giving insertive anal sex in the above time period. Five men reported using a male condom during insertive anal sex between 1-40 times and 2 men reported exchanging insertive anal sex for money. Seven men reported episodes of receptive anal sex, 3 respondents reported multiple (10-40) episodes in the prior three months of the study. Five men reported using a male condom for receptive anal sex between 1-40 times during the preceding three months and 1 man reported exchanging money for receptive anal sex during this same time period.
Bivariate Results

The aim of this research was to establish whether structural-level factors of poverty, homelessness and incarceration predict micro-level factors such as, sex risk behaviors that place Black, African American and Latina/o non-injection drug users living in or close to poverty at risk for HIV infection. The aim of the bivariate analyses was to individually assess the relationship between incarceration, homelessness and poverty, and episodes of unprotected anal, oral or vaginal sex. The combined effect of these structural variables as predictors of sex risk behavior will be assessed through the use of hierarchical multiple regression in the next section.

Prior to conducting the bivariate and multivariate analyses, variables were screened for missing data, outliers, normality, linearity, and homoscedasticity to ensure that the results of the analyses are valid and unbiased. Few data were missing since the data were collected in the original study by trained interviewers and took place at the study site. Outliers created skewed distributions for the Vaginal Episode Equivalent (VEE) and incarceration history variables. Log transformations performed on these variables resulted in bivariate normality, and residuals in multiple regression showed that these variables had a linear relationship. Finally, bivariate scatterplots showed that variability in scores for the variables VEE, incarceration history and age was roughly the same.

History of Incarceration and Episodes of Unprotected Anal, Vaginal or Oral Sex

Men who had spent time in jail, prison or a juvenile detention were significantly more likely to engage in all types of unprotected sex \( p = .025; \chi^2 = 11.110, df = 4 \), than men who had not been incarcerated. History of incarceration among men accounted for 25% of the variance in total unprotected sex among male respondents. Men who had reported one or more times of having been in jail, prison or a juvenile detention center were also significantly more likely to
engage in all types of unprotected episodes ($p = .006; \chi^2 = 14.500, df = 4$). Having been in jail one or more times accounted for 28% of the variance in total unprotected sex among male study respondents.

Total unprotected sex episodes were significantly higher ($p = .006; \chi^2 = 14.500, df = 4$) among incarcerated men and women than those not incarcerated, with incarceration accounting for 22% of the variance in total unprotected sex among the men and women of the study. When all of the questions regarding incarceration were recoded to binary levels of measurement, then added together though a target variable, men who reported having been incarcerated any number of times prior to or during the previous six months of the research were significantly more likely to engage in all types of unprotected sex ($p = .028; \chi^2 = 22.942, df = 12$), than men without a history of incarceration. A history of incarceration accounted for 36% of the variance in total unprotected sex episodes among the male research participants.

**History of Homelessness and Episodes of Unprotected Anal, Vaginal or Oral Sex**

Men and women who reported having slept in a car, abandoned building, public park, shelter or other non-dwelling for more than seven consecutive nights in the six months prior to the study were significantly more likely to engage in all types of unprotected sex ($p = .027; \chi^2 = 10.947, df = 4$), than men and women who had not experienced homelessness. Having slept in a non-traditional dwelling for more than seven consecutive nights accounted for 20% of the variance in total unprotected sex episodes among men and women respondents.

**Income from Sources Other Than Regular Work and Episodes of Unprotected Vaginal Sex**

Unprotected vaginal sex episodes were significantly higher among women who received most of their money in the six months prior to the study from public assistance, family and friends or from selling sex ($p = .020; \chi^2 = 32.394, df = 18$), than women who had received most of
their money from regular work. Receiving most of their money from public assistance, friends and family or from selling sex accounted for 61% of the variance in total unprotected vaginal sex episodes among all women respondents in the study. Men and women receiving most of their money in the six months prior to the study form public assistance, family and friends, or from selling sex or drugs were also significantly more likely to engage in unprotected vaginal sex ($p= .51; \chi^2= 32.617, df= 21$), than men and women who had received most of their money from regular work. Receiving most of their money from sources other than regular work accounted for 35% of the variance in total unprotected vaginal sex among all male and female study respondents.

**Income from Regular Work and Episodes of Unprotected Anal Sex**

It is important to note that men who reported receiving money from regular work were significantly more likely to engage in unprotected anal sex ($p= .001; \chi^2= 13.491, df= 2$), than men who had received most of their money from other sources. Receiving most of their money from regular work accounted for 27% of the variance in unprotected anal sex among male respondents. Men and women who received most of their money in the six months prior to the study from regular work were significantly more likely to engage in anal sex ($p= .006; \chi^2= 10.075, df= 2$) than men and women who had received most of their money from other sources. Receiving money from regular work accounted for 20% of the variance in total unprotected anal sex episodes among men and women research participants. Thirteen percent ($n=14$) of men and women who reported receiving money from a regular job also listed five or more episodes of unprotected anal sex.
Income from Regular Work and Episodes of Unprotected Vaginal Sex

Episodes of unprotected vaginal sex were significantly higher among women who did not receive money from regular work in the three months prior to the study (p = .003; \( \chi^2 = 13.968 \), df = 3), than among women who reported regular work as an income source. Not receiving money from regular work accounted for 40% of the variance in total unprotected vaginal sex among women study participants. Overall, men and women who did not receive money from regular work in the three months prior to the study were significantly more likely to engage in unprotected vaginal sex (p = .045; \( \chi^2 = 8.125 \), df = 3) than men and women who received money from regular work. Receiving money from regular work accounted for 17% of the variance in total episodes of unprotected vaginal sex among men and women respondents. Twenty-two percent (n=35) men and women did not receive money from regular work and reported between 10-29 episodes of unprotected vaginal sex.

Income from Regular Work and Episodes of Unprotected Anal, Vaginal or Oral Sex

Women who did not receive money from regular work in the three months prior to the study were significantly more likely to engage in all unprotected sex (p = .004; \( \chi^2 = 15.125 \), df = 4) than women who had received money from regular work. No receiving money from regular work accounted for 42% of the variance in total unprotected sex of all types among women study participants. Fifty-six percent (n=10) women who reported 37 or more episodes of unprotected sex did not receive money from regular work. Overall, men and women who did not receive money from regular work were significantly more likely to engage in all types of unprotected sex (p = .046; \( \chi^2 = 9.174 \), df = 4), than men and woman who received money from regular work. Not receiving money from regular work accounted for 19% of the variance in total unprotected sex.
episodes of all types among male and female study participants.

**Income from Selling Sex and Episodes of Unprotected Vaginal Sex**

Men and women who received money for sex were significantly more likely to engage in unprotected vaginal sex \( (p< .0001; \chi^2= 20.713, \text{df}= 3) \) than men and women who had not received money for sex. Exchanging sex for money accounted for 28% of the variance in total unprotected vaginal sex episodes among men and women study participants. Men who received money from selling sex were significantly more likely to engage in unprotected vaginal sex \( (p= .012; \chi^2= 10.893, \text{df}= 3) \), than men who had not exchanged sex for money. Exchanging sex for money accounted for 25% of the variance in total unprotected vaginal sex episodes among men of the study. Episodes of unprotected vaginal sex were also significantly higher among women who received money for sex \( (p= .023; \chi^2= 9.530, \text{df}= 3) \), than women who had not received money for sex. Exchanging sex for money accounted for 33% of the variance of total episodes of unprotected vaginal sex among women respondents of the study.

**Income from Selling Sex and Episodes of Unprotected Anal, Vaginal or Oral Sex**

Men and women who exchanged sex for money were significantly more likely to engage in unprotected sex of all types \( (p< .0001; \chi^2= 23.822, \text{df}= 4) \), than men and women who had not exchanged sex for money. Selling sex for money accounted for 30% of the variance for unprotected sex episodes of all types among men and women study respondents. Ninety-percent \( (n=37) \) of men and women who received money from selling sex reported episodes of unprotected vaginal, anal or oral sex. Men who received money from selling sex were significantly more likely to engage in unprotected sex of all types \( (p= .009; \chi^2= 13.549, \text{df}= 4) \) than men who had not received money for sex. Selling sex accounted for 27% of the variance of all types of unprotected sex among male research participants. Eighty-four percent \( (n=12) \) of
men who received money for sex reported episodes of unprotected vaginal, anal or oral sex.

Episodes of all types of unprotected sex were significantly higher among women who had received money for sex (p=.016; $\chi^2=12.234$, df=4), than women who had not exchanged sex for money. Exchanging sex for money accounted for 30% of the variance of total episodes of unprotected sex among all female study respondents. Ninety-three percent (n=25) of the women who received money in exchange for sex reported episodes of unprotected vaginal, anal or oral sex.

**Highest Level of Education Completed and Episodes of All Unprotected Sex and Vaginal Sex**

Women who completed all or some high school education were more likely to engage in episodes of unprotected vaginal, anal and oral sex (p=.087; $\chi^2=24.137$, df=16), than women who completed some or all of college education and women with an eighth grade education or less. Having completed all or some high school education accounted for 53% of the variance in unprotected sex among women study respondents. Episodes of unprotected vaginal sex were also higher among women who had completed all or some high school education (p=.088; $\chi^2=19.007$, df=12), than women who had less education and women who had completed all or some college education. Completing all or some high school education accounted for 47% of the association in unprotected vaginal sex among women research participants. The relationship between highest level of education completed and episodes of unprotected sex were approaching statistical significance.
Multivariate Results

Multiple regression analysis pools together the structural level variables that, when combined, could have an influence on episodes of unprotected sex. While variable relationships may be approaching statistical significance in bivariate analysis, they may produce statistically significant findings when combined with other variables. The dissertation hypothesis that structural variables of incarceration, homelessness and income predicted sex risk behavior was tested by conducting stepwise multiple regression (forward selection) analysis. The independent variables that were selected for the regression equation that was tested included age, sex, ethnicity, education (enrolled in school in the 6 months prior to study participation), income source, homelessness, and number of times in jail, prison or detention. Total unprotected vaginal, anal and sex episodes (Vaginal Episode Equivalent) was selected as the dependent variable. Age, sex and ethnicity were included in the model to control for the effects of these variables on the primary independent variables of interest.

Stepwise multiple regression was performed after the data were again screened for missing cases, outliers, normality, linearity and homoscedasticity. The coefficient table, model summary and ANOVA table and are presented in Tables 4, 5 and 6 respectively. Tolerance among all the independent variables is adequate since all the coefficients for all the independent variables included and excluded are above 0.1. Tolerance ranges from 0-1, with zero indicating multicollinearity. Multicollinearity is when the covariate relationships are not independent of one another, but are instead, overlapping and cannot be used for multivariate analysis. Any tolerance figures above .100 to .999 indicate that the covariate relationships are independent of one another and can be utilized in multivariate regression analysis to build models and measure predictability.
Table 4

*Independent Variable Coefficients*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1. Income from Sex</td>
<td>1.084</td>
<td>.504</td>
</tr>
<tr>
<td>2. Income from Sex</td>
<td>1.101</td>
<td>.499</td>
</tr>
<tr>
<td>Episides of Incarceration</td>
<td>.044</td>
<td>.021</td>
</tr>
</tbody>
</table>

Since the Stepwise method was utilized, only those independent variables that significantly predicted the dependent variable were entered into the final model as indicated in the model summary (see Table 5).

Table 5

*Model Summary*

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>adj R²</th>
<th>Std Error</th>
<th>R² change</th>
<th>F change</th>
<th>df1</th>
<th>df2</th>
<th>Sig F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.153</td>
<td>.023</td>
<td>.018</td>
<td>2.53760</td>
<td>.023</td>
<td>4.631</td>
<td>1</td>
<td>193</td>
<td>.033</td>
</tr>
<tr>
<td>2</td>
<td>.213</td>
<td>.035</td>
<td>.035</td>
<td>2.51544</td>
<td>.022</td>
<td>4.415</td>
<td>1</td>
<td>192</td>
<td>.037</td>
</tr>
</tbody>
</table>

For the first step, income from sex was entered into the model because it accounted for the most unique variance in sex risk behavior (R²=.023, R²adj = .018, F(1, 193)= 4.631, p= .033).

Frequency of incarceration was entered in the next step. Regression results indicate that an
overall model of two predictors (income from sex and frequency of incarceration) significantly predict episodes of unprotected sex ($R^2 = .045$, $R^2_{adj} = .035$, $R^2_{\Delta} = .022$, $F(2, 192) = 4.564$, $p = .012$). This model accounted for 4.5% of the variance in sex risk behavior. The ANOVA table (see Table 6) presents the $F$-test for each model.

Table 6

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>29.819</td>
<td>1</td>
<td>29.819</td>
<td>4.631</td>
<td>.033</td>
</tr>
<tr>
<td>Residual</td>
<td>1242.806</td>
<td>193</td>
<td>6.439</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1272.625</td>
<td>194</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regression</td>
<td>57.757</td>
<td>2</td>
<td>28.879</td>
<td>4.564</td>
<td>.012</td>
</tr>
<tr>
<td>Residual</td>
<td>1214.868</td>
<td>192</td>
<td>6.327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1272.625</td>
<td>194</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These findings support the study hypothesis that structural variables such as income and incarceration predict sex risk behavior. Both models significantly predicted sex risk behavior. As indicated in the final model, for every unit increase in income from selling sex, unprotected sex episodes increased ($\beta = .155$). In addition, for every unit increase in the number of times in jail, prison or a detention center, unprotected sex episodes increased ($\beta = .148$). In other words, an increase in income from selling sex significantly predicted more episodes of unprotected anal sex.
vaginal and oral sex episodes, and an increase in the number of times in jail, prison or a detention center significantly predicted more episodes of unprotected anal, vaginal and oral sex episodes.
CHAPTER IX: DISCUSSION

This chapter revisits the study purpose while discussing the research findings within the contexts of theoretical and conceptual frameworks for the study. Contributions from and limitations of the research are identified and suggestions for future research are made. Unexpected research findings and the opportunities that they offer to social work practice are outlined.

Study Purpose and Summary of Findings

The purpose of this research was to investigate the relationship between the structural-level factors of homelessness, incarceration and poverty, and episodes of unprotected vaginal, anal and oral sex among Black, African American and Latina/o communities living in or close to poverty. The study hypothesis stated that participants with a history of incarceration, homelessness and or low/near poverty-level income would report more episodes of unprotected sex than respondents without a history of incarceration, prior episodes of homelessness and or more stable income. Univariate level frequencies illustrated that the variables of interest were present in both the study tools and research sample. Respondents reported about having a history of incarceration, periods of experiencing homelessness, their income sources three-six months prior to the study, and episodes of unprotected vaginal, anal or oral sex.

Bivariate level frequencies illustrated statistically significant relationships among all three structural-level variables and episodes of unprotected sex. Receiving income from sources other than regular work and a history of incarceration had the strongest statistically significant relationships. Stepwise multivariate analyses suggests that incarceration and income predict episodes of unprotected sex. The final model illustrates that unprotected sex episodes increased for every unit increase in income from selling sex ($\beta= .155$), and for every unit increase in the
number of times in jail, prison or a detention center ($\beta= .148$). An increase in income from selling sex significantly predicted more episodes of unprotected anal, vaginal and oral sex episodes, and an increase in the number of times in jail, prison or a detention center significantly predicted more episodes of unprotected anal, vaginal and oral sex episodes.

**Research Findings, and the Conceptual and Theoretical Frameworks of the Dissertation**

The conceptual framework for this dissertation reaffirms a macro-determinants of health perspective in positing that macro-level factors of homelessness, poverty and incarceration negatively affect Black, African American and Latina/o communities. The research findings that incarceration and selling sex as a source of income predicted episodes of sex risk behavior among the study sample underscore the relevance of this conceptual framework and help to explain disproportionate rates of HIV/AIDS among Black, African American and Latina/o communities living in or close to poverty. The findings of this study demonstrate that the billion dollar punishment industry and dwindling social welfare resources are continuing to maintain disproportionate HIV/AIDS rates among communities of color. Social disintegration continues to be the footprint of profit from transferring resources out of Black, African American and Latina/o communities. It is important to note that the billion dollar industry that mass incarceration creates is rivaled in profit only by the enslavement of Blacks and African Americans (Alexander, 2010).

The research findings illustrate a direct and predictor relationship between macro-level structures and micro-level sex risk behaviors. They also demonstrate how global level factors can determine what options are and are not available in communities. An example of this is the move of the factory jobs or sources of regular work out of the US and the rising rates of unemployment among Black, African American and Latina/o communities that immediately
followed (Spence, 2011; Wilson, 1996). Finally, study findings underscore that despite the disproportionality of HIV/AIDS infections, sex risk is not limited to specific sexual identities, one form of sexual practice, gender or source of income.

Both heterosexual men and heterosexual women engaged in anal sex with men. The disproportionalities present in communities of color and the findings of this research illustrate a phenomena of pathological Whiteness that operates through these structures that keep Blacks, African Americans and Latinas/os in proximity to HIV/AIDS infection. It begs to be restated that Black and Brown bodies are both needed and kneaded by political (Schneider & Ingram, 1993), punishment (Alexander, 2010; Davis, 1999) and social welfare institutions (Roberts, 1996) to maintain a pathologically false sense of Whiteness, where no one -- especially White/Euro-Americans, are safe. Although these study findings supported the dissertation hypothesis, other findings emerged that were unexpected.

**Unexpected Findings and their Significance for Social Work Practice**

Some study findings emerged that were unexpected or did not fully support the research hypothesis. Having slept in a car, park or other non-dwelling place for seven consecutive nights in the six months prior to the study accounted for 20% of the variance in episodes of unprotected sex among men and women respondents. However, when all of the questions regarding homelessness were combined, men and women participants with a history of homelessness reported fewer or comparable episodes of unprotected sex, when compared to respondents who had not been homeless, at least within the six months prior to the study. For most respondents, homelessness served as a protective factor against HIV sex-risk behavior. This finding did not support the hypothesis that homelessness predisposed study respondents into engaging in episodes of unprotected sex. This findings inspired me to consider a distinction between
homelessness as a pathway to HIV infection and homelessness as a pathway for serostatus conversion from HIV to AIDS. More research would need to be conducted to investigate this distinction. Similarly, study findings emerged that challenged the widely supported relationship between education levels and living in or moving out of poverty (Rubérgé, 2013).

Based on previous research, I hypothesized that as the level of education decreased, income would also decrease and the number of unprotected sex episodes would increase. The study findings supported this hypothesis, but only for women who had completed all or some high-school education. Women with an eighth grade education or lower, and women who completed all or some of a college education, reported fewer episodes of unprotected vaginal sex than their peers who completed all or some high school. Although these findings are not statistically significant, they offer very key insights for future research and social work practice. The findings of fewer unprotected sex episodes among women who have completed all or some college education can inform social work practitioners that high school completion and going onto college can serve as a component of evidence-based HIV prevention. Supporting Black, African American and Latina women to complete high school and continue onto completing college education, can help to increase their opportunities of economic well-being.

Limitations of Study and Future Research

This study evidences that micro-level data can be used to measure a statistically significant and predisposing relationship between structural-level factors and micro-level sex risk behaviors. However, study findings also illustrate that a larger study sample is necessary for macro-level factors and micro-level relationships to demonstrate stronger statistical significance among more covariate relationships. Findings from this research suggest that it may be informative for community members and social work researchers to investigate the possibility of
homelessness serving as a protective factor against episodes of unprotected sex by interviewing or the secondary data analysis of research with women and men who have been or are homeless about how they navigate protection in sexual encounters. Second, exploring the same relationships that this study investigated but with a larger dataset may heed more statistically significant findings. This may enable the researchers and community members to continue to explore the statistical significance of macro-level factors and micro-level HIV sex-risk behaviors among Black, African American, and Latina/o communities living in or close to poverty, using micro-level data.
CHAPTER X: IMPLICATIONS FOR SOCIAL WORK

This chapter discusses the relationship of the study findings to social work and the contexts of effective HIV prevention, ethical social work practice, and reiterating Pinderhughes’ call to consciousness for all social work practitioners.

**Macro-Level Interventions as a Necessary Part of HIV Prevention**

The findings of this research inform social work practice in important ways. Discovering that a history of having spent time in an incarceration facility and or sources of income can predict HIV sex-risk behavior among adults in Harlem or the South Bronx counters individual-level HIV/AIDS prevention approaches within, that do not address macro-level factors showing up in Black, African American and Latina/o communities living in or close to poverty. Including the relationship between macro-contexts and micro choice-making informs social work practitioners that it is imperative that we deliberately shift our focus to include macro-level interventions as an essential part of effective HIV/AIDS prevention (Poindexter, 2010). These research findings suggest that incorporating a macro-level focus serves as the missing link to increasing the effectiveness of and access to individually-based means of HIV prevention, such as female/male condoms (Auerbach et al., 2011; Wheeler et al., 2010).

**Consciousness as Essential to Ethical Social Work Practice**

Findings from this research support social work practice educators and social work students to think critically about the sense-making of individual-level behaviors, such as condom use, within the context of societal-level policies, such as criminalizing injustice and increasingly punitive social welfare policies. Thinking critically about and making sense of individual behaviors within the context of the environments that the individual and community is immersed in informs social work practitioners to problematize the environment in-place of problematizing
the individual (Pinderhughes, 1983; Bowen, 1978). Pinderhughes (1983) and Rose (2000) remind social workers that we systematically reconstruct our identities in reciprocal relationships and the locations of these relationships within macro-level structures. In essence, what constitutes as social work practice is contingent on the environment within which it takes shape. It is essential to the efficacy of ethical practice that social workers have an informed understanding and consciousness of how structural factors have historically been and continue to be intertwined with micro-level relationships (Lawson & Alameda-Lawson, 2001; Pinterhughes, 1983). The findings of this study add support for facilitation and maintenance of this awareness within the social work imagination. I have coined the term social work imagination to refer to the understanding that social work practitioners employ when making sense of how to apply core social work tenets and values to current-day social problems, injustices and oppressions, such as the disproportionate rates of HIV/AIDS in the US.

The research findings further inform social work professionals and the communities that we serve, of the ways in which macro-systems support or undermine the functioning of individuals and families (Pinderhughes, 1983). Identifying how structural-level factors inform micro-level actions informs the social work professional relationship. These study findings assist social work professionals to identify HIV risk factors in Black, African American, and Latina/o communities as the footprint of societal policies, and individual-level responses to the micro-level presence of these structural policies. As these study findings reiterate, the communities that are hardest and most disproportionately ‘hit’ by HIV/AIDS rates are not the problem. The systems, such as mass incarceration and the maintenance of poverty that have created the conditions for disproportionate rates of HIV infection and that are predisposing members of these communities to engage in sex risk behaviors have been and continue to be the
problem. Approaching HIV/AIDS awareness and prevention from this angle supports social work clients to not blame themselves, but to instead become aware of the ways in which they may be colluding with and push-back against oppressive structures that reinforce their powerlessness (Pinderhughes, 1983). Study findings further present for social workers the necessity for macro-level change as a means of engaging the whole person and addressing community-level resource constraints as core components of the social work intervention.

History illustrates that it is not social work’s role, as a profession, to be on the forefront of this movement for social change for the well-being of people who are living on the margins, including communities of color (see the History of the Social Work Profession and its Concern for Black Citizenship section of this dissertation). As an established and formally recognized profession, social work must follow the directives of the person, agency or foundation that funds its work or accept not getting paid at all (or as much). This conundrum is reiterated throughout the profession’s history of following the direction of the funding sources, even at the cost of abandoning the communities most in need of social support and social justice.

Social work’s commitment to maintaining positive recognition by the medical profession and its accreditation bodies and the Council on social work Education requires that the profession co-sign White supremacist ideals of nationhood of the US (Roberts, 1996; 1997). Going along with these ideals does not challenge the structures that they deliberately produce. Social work is in a prime position to support social change movements in using its access to create access for communities on the margins having their basic needs met. However, the social work profession is also in a position to undermine such movements en-route to protecting its status among the same status-quo communities that maintain and benefit from oppression.
In addition, Piven and Cloward (1978) and Kelley (2008) illustrate that these movements must be organized, owned and led by the people who are fighting to change their social position. However, it is social work’s role to support the resistance and well-being of these communities by using our professional access to create access to having basic needs met and places in which to where community can gather to strategize. Should the profession want to better equip itself to fulfill this role, it can learn a great deal from the legacy and case studies of Black Churches (Tolliver, 1993). Findings from this research re-empower social workers to assist ourselves, people and communities to re-access their own and whole person by getting to the roots of how constructs of Whiteness and oppression are detrimental to everyone that they privilege and marginalize.

Findings that the structural factors of a history of incarceration and sources of income predispose individual-level behaviors challenges social work professionals to consider which other relationships are also informed by structural-based factors predisposing micro-level factors. The study findings support social work research being used as a tool to counteract condemnatory sense-making of the distribution of HIV/AIDS prevalence and communities that are in closest proximity to this infection (Allen-Meares & DeRoos, 1997). In sum, the findings from this research have interdisciplinary ramifications. The added support for a predisposing relationship between macro-level factors and micro-level actions necessitates that the New York Board of Education to revamp required health classes to more current and up-to-date standards of HIV/AIDS education curricula (Hart, 2013), revitalizing health classes throughout the US to re-envision what health can mean when it is informed by the context of the individual within the community, within its environment.
CHAPTER XI: CONCLUSION

This chapter summarizes the dissertation problem area, the research it completed and how the study findings are inspiring the trajectory of my career. The legacies of Black, African American, and Latina/o communities are discussed in the context of the role of the social work profession in supporting their well-being.

This dissertation successfully investigated the relationship between the structural-level factors of homelessness, incarceration and poverty, and micro-level sex risk behaviors through the use secondary data analysis of the base-line data from a micro-level dataset. The respondents of the study comprised a non-probability convenience sample, which limits it from being a representative sample. The sample size, however, is sufficiently large enough to allow for generalizations about Black, African American and Latina/o non-injection users in Harlem and the South Bronx. Using hierarchical regression analysis, findings demonstrate that an increase in income from selling sex significantly predicted more episodes of unprotected sex, and an increase in the number of times incarcerated significantly predicted more episodes of unprotected sex.

In a bivariate correlation, having been incarcerated and selling sex for money were statistically significant at p<.001 for men and women combined and for both men and women separately. The sample for this relationship consists of 44 respondents and is large, statistically speaking, but not representative of all drug users who have been incarcerated. The dissertation findings can be used to inform macro-level decision making for effective HIV prevention among communities of color that engage in non-injection drug use. Study findings confirm that HIV transmission risk is disproportionately present among people that have a history of having been incarcerated, even if they are not currently incarcerated.
The findings of this dissertation inspire me to want to explore HIV/AIDS prevention approaches in countries that have lower rates of infection than the US. Similar to the trajectory of HIV in the US, Germany was not fully prepared to meet the challenges that AIDS presented as an emerging infectious disease in 1982 (Hamouda, 2003). However, Germany has managed to stabilize HIV prevalence to 3,000 new infections per year (Kuecherer, 2008); a fraction of the 50,000 new infections that the US incurs annually (CDC, 2014a). Experts attribute Germany’s effectiveness in addressing the HIV/AIDS pandemic to engaging the Gay Men’s Movement early in the onset of the disease, and having a near universal health care system that provides access to quality medical care (WTOP, 2012).

In the US, individually-based behavioral change approaches to HIV-prevention continue to be the most widely promoted and funded methods of combating HIV-risk in Black and African American communities (Sutton, et.al., 2009), even with the emergence of legislation that could potentially medically insure more people than ever before in the history of the US. The era of focusing on condom use as a main approach to HIV prevention is swiftly shifting into an era of biomedicalization, where any calls for attention to dismantling the mass incarceration system and eradicating poverty are identified as unnecessary, unachievable or simply not supported by empirical evidence (Green & Ruark, 2011).

The medicalization of HIV/AIDS prevention maintains individual-level approaches that have less efficacy than condom use and do not interfere with the structural-drivers of this infection. I am interested in traveling to Germany to explore how it has successfully thwarted HIV/AIDS rates within its borders. I am most interested in learning about how communities, on a micro-level, are ensuring their well-being in this age of HIV infection. The trajectories of Black, African American and Latina/o health in the US that this dissertation presents illustrate
that these communities in the US have a legacy of self-help, doing for themselves and doing what they can to ensure that the needs of their communities are met to the best of their ability.

Communities of color in the US did not wait for anyone, other than themselves, to address the health deficits that continue to be present in these communities. Self-help and hard work are more of the legacy of Black, African American, and Latina/o communities, than anything else that blackness and Latino/o culture has come to be associated with. The actions of members of these communities and their allies provided thousands of people with much needed medical care, financial assistance and other important needs. However, they have only been able to provide a fraction of the resources that were and continue to be needed to completely address the health disparities that they continue to face. Black Churches have historically exemplified what it can look like on micro/macro-levels to support Black communities to have their basic needs met (Tolliver, 1993). The legacies of these communities inform social workers that it is possible for us to develop our social work communities to enable us to sustain ourselves in the work that matters most.
APPENDIX I: FIGURE 1: GRAPHIC MODEL OF PRIMARY STUDY DESIGN

INFORMATION

300 NIDUs (Index Subjects)
Randomized

150 Experimental Index Subjects
+ 300 Experimental Network Subjects
undergo baseline assessment

COPE-NETWORK INTERVENTION
150 Exp. Index + 300 Exp. networks

450 Exp. Index & Network Subjects Undergo:
1) Post-Intervention Assessment
2) 6-Month Assessment
3) 12-Month Assessment

360 Complete Study @
(Includes 120 index subjects + 240 network subjects)

150 Experimental Index Subjects
+ 300 Experimental Network Subjects
undergo baseline assessment

CONTROL CONDITION
150 Control Index Subjects Only

450 Exp. Index & Network Subjects Undergo:
1) Post-Intervention Assessment
2) 6-Month Assessment
3) 12-Month Assessment

360 Complete Study @
(Includes 120 index subjects + 240 network subjects)
APPENDIX II: DATA EXTRACTION SHEET

Demographic Questions

1. What is your date of birth? __/__/_____mm/dd/yyyy

2. What is your sex? Or what sex do you consider yourself to be? (Choose one)
   01 Male
   02 Female
   03 Transgender/Transsexual

3. Do you consider yourself to Hispanic or Latino?
   00 No  **skip to 5**
   01 Yes

4. Which of the following best describes your ethnic background?
   00 Spaniard, from Spain
   01 Mexican
   02 Central American
   03 South American
   04 Puerto Rican
   05 Cuban
   06 Dominican
   07 Other

5. How would you describe your racial background?
   01 Asian
   02 Black or African American
   03 American Indian or Alaska Native
   04 Native Hawaiian or Other Pacific Islander
   05 White
   06 Other or Mixed

6. In the past 6 months, have you been enrolled in school anytime?
   00 No
   01 Yes

7. What is the highest level of education completed?
   01 8th grade or less
   02 Some high school (9th to 11th grade)
   03 High school graduate (12th grade) or GED
   04 Some college or technical training
   05 College graduate or higher
8. In the past 3 months, did you receive any money from any of the follow sources? 1=yes, 0=no (Please write in 1 or 0 for each option)
   __ Regular job, employed with a regular salary (full or part-time)
   __ Temporary work or odd jobs
   __ Recycling cans, returning bottles for deposits, or panhandling
   __ Public assistance or disability
   __ Family or friends
   __ Theft, robbing or stealing
   __ Selling drugs, running or touting
   __ Sex for money

9. In the past 6 months, where did you get most of your money? Choose one
   01 Regular job, employed with a regular salary (full or part-time)
   02 Temporary work or odd jobs
   03 Recycling cans, returning bottles for deposits, or panhandling
   04 Public assistance or disability
   05 Family or friends
   06 Theft, robbing or stealing
   07 Selling needles
   08 Selling drugs, running or touting
   09 Sex for money

10. In the past 6 months, where have you live or slept most of the time? Choose one
    01 Your parents house or apartment
    02 Your own house or apartment (Not your parent’s house)
    03 Someone else’s house or apartment
    04 Rented room (hotel, motel, or rooming house)
    05 Abandoned buildings, care or other vehicle, on the streets
    06 Shelter, welfare residence
    07 Jail (prison, detention center, juvenile hall)
    08 Halfway house or treatment facility
    09 Other

11. As a child, did you ever live in an orphanage, a foster home, an group home, or were in foster care?
    00 No
    01 Yes
    88 Refuse to answer

12. IN the past 6 months, have you slept in a car, abandoned building, public part, shelter, or other non-dwelling for more than 7 consecutive nights?
    00 No
    01 Yes
    88 Refuse to answer
13. In the past 3 months, have you been homeless?
   00  No
   01  Yes
   07  Don’t Know
   88  Refuse to answer

14. Have you ever spent time in jail, prison or a juvenile detention?
   00  No  End interview here
   01  Yes
   88  Refuse to answer

15. How many times have you been in jail, prison or juvenile detention center?  _ _

16. When was the last time you got out of jail, prison, or juvenile detention center?
   Please enter the date  _ _/_ _/_ _ _ _ mm/dd/yyyy

17. Is #16 an incomplete date?
   00  No
   01  Yes

SECTION A: SEXUAL BEHAVIOR

This next part of the interview is about sexual behaviors. People have different words they use when they talk about sex and I want to make sure I use words that work for you. When we say “sex” we mean vaginal, oral or anal sex. This would include paid or unpaid sex and whether you wanted to do it or not. Please remember all your responses will be kept private and you can refuse to answer any question.

If male participant, go to page 7, item M1.

CURRENT PARTNERS - WOMEN WITH MALE PARTNERS - CHART 1

W1. When you think about sex, do you think of yourself as . . (Interviewer: READ ALL CHOICES AND CIRCLE THE APPROPRIATE ANSWER):

1........Straight

2........Bisexual

3........Gay/Lesbian

4........Other (Specify: _________________________________________________________)
During this part of the interview, we’ll be talking about your sex life in the last 3 months. So it’s the time period from (DATE, 3 MONTHS AGO) to (TODAY’S DATE). Can you remember anything that was happening in your life about 3 months ago that makes the last 3 months stand out for you?

SIGNIFICANT MARKER__________________________________________________________

_____________________________________________________________________________

Let’s talk about your sexual relationships with men.

W2. Have you had any vaginal, oral, or anal sex with a man in the last 3 months?
   0.....NO (IF NO SKIP TO PAGE 6, W17)
   1.....YES

W3. When was the last time you had sex with a male partner in the last 3 months?
   ______/_______
   Month/ Year

I’d like to ask you some questions about these sexual relationships. I’ll want to know how many men you had vaginal, oral, or anal sex with in the last 3 months and how many times you had sex with each one of them. So that we don’t mix up your male partners I will ask you for their first names or initials, but don’t give me their last names because I want to keep them confidential.

W4. What is the first name or initial of your most recent (THEN NEXT) male partner?
   (REPEAT TO RECORD ALL DIFFERENT MALE PARTNERS SINCE DATE, 3 MONTHS AGO OR SIGNIFICANT MARKER. RECORD INFO ON CHART 1, W4)

W5. Women think of their partners in many ways. For the purpose of this interview, please look at this list and pick the description that fits your partner(s) best.
   1. Someone you had sex with once and don’t plan to again.
   2. Someone you just had sex with occasionally.
   3. A lover you’ve been with for a while.
   4. An ex-lover you go back together with temporarily.
   5. Someone you’re starting or plan to start a new relationship with.
   6. Someone you know well but don’t plan to become steady partners.
   7. Someone you know slightly but don’t plan to become steady partners.
   8. Someone you had sex with in order to get money, rent, drugs or other things.
   9. Spouse
   10. Fiancé
   11. Other

What number best fits (NAME OR INITIAL FROM W4)? [REPEAT FOR ALL MALE PARTNERS AND ENTER ON CHART 1, W5]
W6. About how many times altogether would you say you had sex of any kind with (NAME OR INITIAL) in the Last 3 months? [REPEAT FOR ALL PARTNERS AND INSERT IN CHART 1, W6]

W7. I’d like to ask some additional questions about the male partner(s) in the last 3 months. To the best of your knowledge, can you tell me if [NAME OR INITIAL] . . . . . .

<table>
<thead>
<tr>
<th></th>
<th>a. had sex with another partner since you and he first became sexually involved? [CHART 1, W7A]</th>
<th>0=NO</th>
<th>1=YES</th>
<th>2=DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b. ever had sex with men? [CHART 1, W7B]</td>
<td>0=NO</td>
<td>1=YES</td>
<td>2=DON’T KNOW</td>
</tr>
</tbody>
</table>

[REPEAT WITH ALL MALE PARTNERS, RECORD ON CHART 1, W7A AND 7B]

SEXUAL PRACTICES--WOMEN WITH MALE PARTNERS IN LAST 3 MONTHS-
CHART 2

Now, let’s talk in more detail about your sexual activities with your male partner(s) during the last 3 months. (REPEAT DATES AND REVIEW SIGNIFICANT MARKER IF NECESSARY). You told me that you had sex of any kind with (NAME OR INITIAL) ______ times in the last 3 months.

Any Vaginal Intercourse

W8. Of these ________ times, (CHART 1, W6), how many times did you have vaginal sex with ________? (REPEAT FOR EACH PARTNER AND RECORD IN CHART 2, W8)

[IF 0, SKIP TO PAGE 5, W11]

W9. Women use a variety of protection methods to prevent pregnancy or sexually transmitted diseases (STDs) such as male or female condoms, saran wrap, dental dams or other methods. Please tell us which methods you use. Of the ________ (W8) times you had vaginal sex IN THE LAST 3 MONTHS with (PARTNER NAME OR INITIAL) how many times did you use:

3. a male condom? __ __ [CHART 2, W9A]

4. a female condom? __ __ [CHART 2, W9B]

5. any other protection? (specify ____________________) __ __ [CHART 2, W9C]
IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED (W9)

W10. Women tell us that they have sex with men for different reasons. Sometimes, they have sex for love, sometimes they have sex in order to get money, rent, drugs, or other things. During the last 3 months, of the _______(W8) times when you had vaginal sex with (NAME OR INITIAL FOR EACH PARTNER), how many times . . . . . . [IF RESPONSE IS NEVER, CODE “00” IN CHART.]

2. . . . . . . . did he give you money? [CHART 2, W10A]
b . . . . . . . did he give you drugs or alcohol? [CHART 2, W10B]

Anal Sex - CHART 4

Now, I’d like to ask about anal sex with your male partner(s) during the last 3 months. (REPEAT DATES AND REVIEW SIGNIFICANT MARKER IF NECESSARY). You told me that you had sex with (NAME OR INITIAL) ________ (Chart 1, W6) times in the last 3 months.

W14. Of these ________ times, how many times did you have anal sex with him? (CHART 4, W14)

[If 0, Skip to Page 6, W17]

W15. As we discussed, women use a variety of protection methods to prevent pregnancy or sexually transmitted diseases (STDs) such as male or female condoms, saran wrap, dental dams or other methods. Please tell us which methods you use. Of the ________ (W14) times you had anal sex IN THE LAST 3 MONTHS with (PARTNER NAME OR INITIAL) how many times did you use:

2. a male condom? __ __ [CHART 4, W15A]
3. a female condom? __ __ [CHART 4, W15B]
4. any other protection? (specify ________________________) __ __ [CHART 4, W15C]

IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED (CHART 4, W15)

W16. Women tell us that they have sex with men for different reasons. Sometimes they have sex with a man for love, sometimes they have sex in order to get money, rent, drugs, or other things. During the last 3 months, of the _____ (Q14) times when you had anal sex with (NAME OR INITIAL), how many times . . . . . . [IF RESPONSE IS NEVER, CODE “00” IN CHART 4.]
1. . . . . . did he give you money? [Chart 4, W16A]

1. . . . . . . did he give you drugs or alcohol? [Chart 4, W16B]

CURRENT PARTNERS - MALE WITH FEMALE PARTNERS - CHART 5

M1. When you think about sex, do you think of yourself as . . . (Interviewer: READ ALL CHOICES AND CIRCLE THE APPROPRIATE ANSWER):

1........Straight

2........Bisexual

3........Gay/Lesbian

4........Other (Specify: ________________________________)

During this part of the interview, we’ll be talking about your sex life in the last 3 months. So it’s the time period from (DATE, 3 MONTHS AGO) to (TODAY’S DATE). Can you remember anything that was happening in your life about 3 months ago that makes the last 3 months stand out for you?

SIGNIFICANT MARKER__________________________________________________________

Let’s talk about your sexual relationships with women.

M2. Have you had any vaginal, oral, or anal sex with a man in the last 3 months?

0.....NO (IF NO SKIP TO PAGE 11, M17)

1.....YES

M3. When was the last time you had sex with a female partner in the last 3 months?

______/_______

Month/ Year

I’d like to ask you some questions about these sexual relationships. I’ll want to know how many women you had vaginal, oral, or anal sex with in the last 3 months and how many times you had sex with each one of them. So that we don’t mix up your male partners I will ask you for their fist names or initials, but don’t give me their last names because I want to keep them confidential.
M4. What is the first name or initial of your most recent (THEN NEXT) female partner? 
(REPEAT TO RECORD ALL DIFFERENT MALE PARTNERS SINCE DATE, 3 MONTHS AGO OR SIGNIFICANT MARKER. RECORD INFO ON CHART 5, M4)

M5. Men think of their partners in many ways. For the purpose of this interview, please look at this list and pick the description that fits your partner(s) best.

1. Someone you had sex with once and don’t plan to again.
   a) Someone you just had sex with occasionally.
   b) A lover you’ve been with for a while.
   c) An ex-lover you go back together with temporarily.
   d) Someone you’re starting or plan to start a new relationship with.
   e) Someone you know well but don’t plan to become steady partners.
   f) Someone you know slightly but don’t plan to become steady partners.
   g) Someone you had sex with in order to get money, rent, drugs or other things.
   h) Spouse
   i) Fiance
   j) Other

What number best fits (NAME OR INITIAL FROM W4)? [REPEAT FOR ALL FEMALE PARTNERS AND ENTER ON CHART 5, M5]

M6. About how many times altogether would you say you had sex of any kind with (NAME OR INITIAL) in the Last 3 months? [REPEAT FOR ALL PARTNERS AND INSERT IN CHART 5, M6]

M7. I’d like to ask some additional questions about the female partner(s) in the last 3 months. To the best of your knowledge, can you tell me if ________ [NAME OR INITIAL] had sex with another partner since you and she first became sexually involved?

0 No
1 Yes
2 Don’t know

[REPEAT WITH ALL FEMALE PARTNERS AND RECORD ON CHART 5, M7]

SEXUAL PRACTICES--MEN WITH FEMALE PARTNERS IN LAST 3 MONTHS--CHART 6

Now, let’s talk in more detail about your sexual activities with your female partner(s) during the last 3 months. (REPEAT DATES AND REVIEW SIGNIFICANT MARKER IF NECESSARY). You told me that you had sex of any kind with (NAME OR INITIAL) ______ (CHART 5, M6) times in the last 3 months.
Any Vaginal Intercourse

M8. Of these ________ times, (CHART 5, W6), how many times did you have vaginal sex with ________? (REPEAT FOR EACH PARTNER AND RECORD IN CHARD 2, M8)

[IF 0, SKIP TO PAGE 9, M11]

M9. Men use a variety of protection methods to prevent pregnancy or sexually transmitted diseases (STDs) such as male or female condoms, saran wrap, dental dams or other methods. Please tell us which methods you use. Of the ________ (M8) times you had vaginal sex IN TEH LAST 3 MOTHS with (PARTNER NAME OR INITIAL) how many times did you use:

a. a male condom? __ __ [CHART 6, M9A]

b. a female condom? __ __ [CHART 6, M9B]

c. any other protection? (specify ____________________) __ __ [CHART 6, M9C]

IF NO METHOD USED, PLEASE CODE “00” FOR REACH RESPONSE TO THE NUMBER OF TIMES METHOD USED (CHART 6, M9)

M10. Men tell us that they have sex with women for different reasons. Sometimes, they have sex for love, sometimes they have sex in order to get money, rent, drugs, or other things. During the last 3 moths, of the ________ (M8) times when you had vaginal sex with (NAME OR INITIAL FOR EACH PARTNER), how many times . . . . . . [IF RESPONSE IS NEVER, CODE “00” IN CHART.]

a) . . . . . . did she give you money? [CHART 6, M10A]

b . . . . . . did she give you drugs or alcohol? [CHART 6, M10B]

Anal Sex - CHART 8

Now, I’d like to ask about anal sex with your male partner(s) during the last 3 months. (REPEAT DATES AND REVIEW SIGNIFICANT MARKER IF NECESSARY). You told me that you had sex with (NAME OR INITIAL) ________ (Chart 5, M6) times in the last 3 months.

M14. Of these ________ times, how many times did you have anal sex with her? (CHART 8, M14)
M15. As we discussed earlier, men use a variety of protection methods to prevent STDs such as male or female condoms. Of the ________ (M14) times you had anal sex IN THE LAST 3 MONTHS with (PARTNER NAME OR INITIAL) how many times did you use:

a. a male condom? __ __ [CHART 8, M15A]

b. a female condom? __ __ [CHART 8, M15B]

IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED (M15)

M16. Men tell us that they have sex with women for different reasons. Sometimes they have sex with women for love, sometimes they have sex in order to get money, rent, drugs, or other things. During the last 3 months, of the _____ (M14) times when you had anal sex with (NAME OR INITIAL), how many times . . . . . . [IF RESPONSE IS NEVER, CODE “00” IN CHART 8.]

b. . . . . . . . did she give you money? [Chart 8, M16A]

2. . . . . . . . did she give you drugs or alcohol? [Chart 8, M16B]

CURRENT PARTNERS - MALE WITH MALE PARTNERS

Let’s talk about your sexual relationships with men.

M17. Have you had any oral or anal sex with a man in the last 3 months?

0.....NO (IF NO SKIP TO PAGE 16, BM1)

1.....YES

M18. When was the last time you had sex with a male partner in the last 3 months?

Month/ Year

I’d like to ask you some questions about these sexual relationships. I’ll want to know how many men you had oral or anal sex with in the last 3 months and how many times you had sex with each one of them. So that we don’t mix up your male partners I will ask you for their fist names or initials, but don’t give me their last names because I want to keep them confidential.
M19. What is the first name or initial of your most recent (THEN NEXT) male partner? (REPEAT TO RECORD ALL DIFFERENT MALE PARTNERS SINCE DATE, 3 MONTHS AGO OR SIGNIFICANT MARKER. RECORD INFO ON CHART 9, M19)

M20. Men think of their partners in many ways. For the purpose of this interview, please look at this list and pick the description that fits your partner(s) best.

1. Someone you had sex with once and don’t plan to again.
   a) Someone you just had sex with occasionally.
   b) A lover you’ve been with for a while.
   c) An ex-lover you go back together with temporarily.
   d) Someone you’re starting or plan to start a new relationship with.
   e) Someone you know well but don’t plan to become steady partners.
   f) Someone you know slightly but don’t plan to become steady partners.
   g) Someone you had sex with in order to get money, rent, drugs or other things.
   h) Other

What number best fits (NAME OR INITIAL FROM M19)? [REPEAT FOR ALL MALE PARTNERS AND ENTER ON CHART 9, M20]

M21. About how many times altogether would you say you had sex with (NAME OR INITIAL) in the last 3 months? [REPEAT FOR ALL PARTNERS AND INSERT IN CHART 9, M21]

M22. I’d like to ask some additional questions about your male partner(s) in the last 3 months. To the best of your knowledge, can you tell me if ________ [NAME OR INITIAL] had sex with another man since you and he first became sexually involved?

0 No
1 Yes
2 Don’t know

[REPEAT WITH ALL MALE PARTNERS AND RECORD ON CHART 9, M22]

SEXUAL PRACTICES--MEN WITH MALE PARTNERS IN LAST 3 MONTHS-CHART 10

Anal Sex - CHART 10

M23. Now, I’d like to ask about anal sex with your male partner(s) during the last 3 months. (REPEAT DATES AND REVIEW SIGNIFICANT MARKER IF NECESSARY). You told me that you had sex with (NAME OR INITIAL) ________ (Chart 9, M21) times in the last 3 months. Of these ________ times, how many times did you have anal sex with him? (CHART 10, M23)
M24. As we discussed earlier, men use a variety of protection methods to prevent STDs such as male or female condoms. Of the ________ (M23) times you had anal sex IN THE LAST 3 MONTHS with (PARTNER NAME OR INITIAL) how many times did you use:

a. a male condom? __ __ [CHART 10, M24A]
b. a female condom? __ __ [CHART 10, M24B]

IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED (M24)

M25. Men tell us that they have sex with men for different reasons. Sometimes they have sex with a man for love, sometimes they have sex in order to get money, rent, drugs, or other things. During the last 3 months, of the _____ (M23) times when you had anal sex with (NAME OR INITIAL), how many times ______ [IF RESPONSE IS NEVER, CODE “00” IN CHART 10]

a) . . . . . . did he give you money? [Chart 10, M25A]

a) . . . . . . . . did he give you drugs or alcohol? [Chart 10, M25B]

M26. Now we’ll ask more detailed questions about anal sex. Of the ________ (M23) times you had sex with ________, how many times did you put your penis into his rectum (i.e. butt, behind) ____? (CHART 11, M26)

ASK FOR EACH PARTNER. IF RESPONSE IS NEVER, CODE “00” IN CHART 11, M26

M27. Of the times you put your penis into his rectum, how many times did you use:

b. a male condom? __ __ [CHART 11, M27A]
c. a female condom? __ __ [CHART 11, M27B]

IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED [CHART 11, M27]

M28. Men tell us that they have sex with men for different reasons. Sometimes they have sex for love, sometimes they have sex in order to get money, rent, drugs, or other things. Of the ________ (M26) times, when you put your penis in your partner’s rectum (i.e. butt, behind), how many times ______ [IF RESPONSE IS NEVER, CODE “00” IN CHART 11]

2. . . . . . . did he give you money? [Chart 11, M28A]
a) . . . . . . . did he give you drugs or alcohol? [Chart 11, M28B]

(CHART 12)
M29. Of the times you had anal sex with _______ (M23), how many times did you partner put his penis in your own rectum (i.e. butt, behind)? ___ ___ [CHART 12, M29]

ASK FOR EACH PARTNER. IF RESPONSE IS NEVER, CODE “00” IN CHART 12, M29. IF “0” FOR ALL, SKIP TO PAGE 15, M32.

M30. Of the times he put his penis into your rectum, how many times, did he use:

a. a male condom? ___ ___ [CHART 12, M30A]

b. a female condom? ___ ___ [CHART 12, M30B]

IF NO METHOD USED, PLEASE CODE “00” FOR EACH RESPONSE TO THE NUMBER OF TIMES METHOD USED [CHART 12, M30]

M31. Of the _______ (M29) times, when your put his penis into your rectum (i.e. butt, behind), how many times . . . . . . [IF RESPONSE IS NEVER, CODE “00” IN CHART 11]

b. . . . . . . did he give you money? [Chart 12, M31A]

a) . . . . . . . did he give you drugs or alcohol? [Chart 12, M31B]
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