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National Alliance of State and Territorial AIDS Directors

In this issue:

Table of Contents: Focus on Deconstructing Gender

- The Intersection of Sexuality, Gender, and Power: Implications for HIV Prevention
- Gender Fluidity and HIV Risk: Beyond the Male/Female Rubric
- At a Crossroads: Past & Present Native American Gender Identity, Sexuality, and HIV Implications
- International Efforts to Address Gender Inequity
- Examining the HIV Epidemic among African American Women through the Lens of Gender: Interviews with Janet Cleveland and Kimberley Dobson
- Hot Topics in Gender Research: Interviews with Ralph DiClemente and Richard Parker
- Conclusion
- Meeting and Planning Calendar

Deconstructing Gender

NASTAD's last two *Prevention Bulletins* have helped frame our understanding of the complex web of social, cultural and health-related realities that impact our work in prevention. July's *Bulletin* presented the idea of syndemics and challenged public health practitioners to consider in their programs the multiple health concerns that conspire to cause negative health outcomes. August's *Bulletin* offered a frank discussion about the link between policy, race and ethnicity and health disparities in minority populations in the U.S. This month's *Bulletin* continues this examination by moving to a conversation about the intersection of sexuality, gender and power. This point of convergence offers yet another critical lens through which we can better understand disease epidemics and our efforts to address them. Because of the ongoing and, at times, complicated debate over the role of gender in social and health outcomes, the stories and interviews in this month's Bulletin were specifically selected to offer a variety of perspectives on the topic.

The first story presents a commentary on the intersection of sexuality, gender and power and highlights important considerations for prevention efforts. The second story moves beyond the traditional construct of "male" and "female," which dominates much of the current discourse, to a focus on the fluidity of gender. The third story features a commentary on gender identity and sexuality from the Native American perspective and details specific implications for HIV prevention efforts in this population. Through a discussion of structural level interventions, the fourth story examines international efforts to address gender inequality and its role in the HIV/AIDS epidemics.

This month's *Bulletin* concludes with a series of interviews. Janet Cleveland and Kimberley Dobson, leaders in America's federal and state public health systems, respectively, share their perspectives on the U.S. epidemic among African American women and, specifically, the role gender plays in the disproportionate impact of HIV on this population. The final two interviews present perspectives from leading researchers on the topic of gender in the context of HIV prevention. Ralph DiClemente shares his thoughts and current

work on developing HIV prevention interventions for African American women. Richard Parker offers his perspective on the importance of gender in HIV prevention work with men who have sex with men (MSM).

To honor the complexity of this topic, the stories and interviews in this issue were not forced into a pre-determined outline, but rather, are presented as independent perspectives. Together, we believe these perspectives illuminate important considerations about gender that must be taken as we work to prevent as many new HIV infections in the U.S. as possible.

The Intersection of Sexuality, Gender, and Power: Implications for HIV Prevention

Social scientific research increasingly elucidates the cultural, structural, political and economic factors that influence vulnerability for health and social conditions, including HIV/AIDS. At the same time, our knowledge and understanding of sexuality and sexual identity is lacking, particularly related to vulnerability and risk for HIV, hepatitis B (HBV) and sexually transmitted diseases (STD). Since the beginning of the HIV/AIDS epidemic, prevention research has approached sexuality from the perspective of quantifying and categorizing a specific set of practices (e.g., how often men have unprotected anal intercourse). This approach does not, however, adequately account for the enormous variety of sexual practices, the contexts in which various sexual practices take place or the meanings and consequences associated with these practices.[1,2,3]

Our sexual lives are tremendously complex. How we manage and experience them is informed by the interaction of cultural, structural, political and economic factors which structure our sexual interactions and relationships. These factors determine with whom we may have sex, in what situations, in what ways, and with what intended outcomes. While the "rules" of sex are culturally defined, they are also informed and influenced by the political and economic power relations that underpin every cultural system. Sexual relations, their meanings and their consequences cannot be fully understood without examining notions of race, ethnicity, gender or myriad other contexts through which communities organize differences and social inequalities.[4]

Gender and sexuality are inextricably intertwined, yet gender is not a synonym for biological sex. Gender, in contrast to biological sex, is culturally constructed and comes with a set of "rules" which both structure and mediate sexual relations. The culturally-determined "rules" about sex associated with gender are situational and dynamic and vary across communities and cultures. Further, the "rules" influence the ways in which communities organize sexual differences and inequalities and negotiate sexual interactions.

Within gender "rules," there are important differences in what women and men can and cannot do (or are expected to do or not to do) in all spheres of social interactions, including sexual relations. For example, what constitutes an "ideal" behavior (e.g., chastity until marriage), may not be reflected in normative behavior (e.g., sex outside of marriage with a "committed" partner). By the same token, what constitutes "good" or "appropriate" behavior in one situation (e.g., husbands are the assertive partners in sex), may not hold in another (e.g., girlfriends or other women who are sexually aggressive are "exciting"). Gender-specific "rules" about sexual roles and behavior may also be conflicting (e.g., chastity until marriage for women is "ideal" while sexual "experience" for men is expected). The situational, dynamic and sometimes conflicting nature of gendered "rules" for sexual behavior have important implications for HIV prevention because they influence how risk is perceived and determine what practices or behaviors are acceptable, both in terms of sexual pleasure and HIV risk reduction.

While we generally think of gender in terms of a dichotomy, "man" and "woman," each having specific and distinct roles and sets of expected behaviors, gender as a construct is relatively fluid and dynamic. This is evidenced by the presence of transgender persons in contemporary society and "third genders" in other cultures. The fluidity of gender complicates prevention efforts because the "rules" for sexual behavior are less clear and precise as are the types of interventions that might be appropriate and effective to address risk behaviors. This underscores the importance of looking beyond this simple dichotomy in order to gain a fuller appreciation and understanding of the ways in which gender both structures and mediates sexual behavior and, ultimately, effective prevention strategies.

At the same time, we tend to overlook the construct of gender when thinking about sexuality in the context of same-sex relationships, particularly between men. In fact, gender is a salient construct in the context of

same-sex relationships. Like in opposite sex relationships, gender does structure and mediate sexual interactions between persons of the same-sex, making it an important construct to consider relative to sexuality, sexual practices and risk for HIV/AIDS. Richard Parker's research among gay men in Brazil revealed that notions of activity/passivity and masculinity/femininity are incorporated into identity, inform sexual behavior and mediate perception of HIV risk.[5] Michael Tan's[6] research among Filipino men similarly demonstrated that notions of femininity are salient in structuring sexual relations between men, and, as a result, influence perception of sexual risk and actual HIV risk behaviors. In this way, examination of gender is essential to gaining a fuller understanding about how sexuality and sexual practices between same-sex persons are shaped and influenced according to gender-specific "rules."

The awareness of social constructs, like gender, has drawn attention to socially and culturally determined differentials in power, particularly between men and women. Because power is fundamental to both sexuality and gender, inequalities in power in gender relations translate into inequalities in power in negotiating sexual interactions. Gendered power relations, therefore, are a key issue for HIV prevention because they affect one's ability to accurately perceive risk or to conceive, propose or adopt risk reduction strategies. They do this by constraining access to information (e.g., about one's body, disease, prevention strategies), resources (e.g., access to health care, risk reduction materials, skills development) and social support, including norms which support behaviors that promote health and wellness and prevent disease.

It is important to understand, however, that power is neither a monolithic or pre-existing social structure. A person does not "have" power while another does not. Rather, power exists only in the context of human interaction. Indeed, power, or more correctly, the expression of power, is contextual and nuanced.[7] In a given circumstance, one person may exercise relatively greater power over another by virtue of his access to information, resources or social support which legitimize and support his/her expression of power.

Because the reciprocal and reinforcing relationship between gender and power plays a significant role in mediating sexual interactions, HIV prevention efforts are increasingly focused on addressing and mitigating gender power inequalities. Women receive particular emphasis in these prevention efforts which seek to "empower" them to negotiate sexual situations by using risk reduction strategies, like condom use. It is important, however, that programs designed to address gender power inequalities serve men as well. In recognition of the fact that gender power inequalities are also at play in same-sex sexual relations, these empowerment approaches may also have value in strengthening prevention efforts for men who have sex with other men.

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Gender Fluidity and HIV Risk: Beyond the Male/Female Rubric

As previously discussed, social science generally holds that gender is a socially-constructed concept, meaning that the way gender is thought about by a culture is related to the meanings and values that culture ascribes to the various roles its members assume. While the scholarship on gender has been ever evolving and changing, much of it has been rooted in a theoretical approach that views both biological sex and gender in two sets of categorical terms: male/female and man/woman.[1]

However, throughout history there are examples of cultures that make room for more than two genders, accepting and recognizing gender roles other than man/woman. Some have referred to these examples as evidence of a "third gender."[2,3] Commonly recognized examples of cultures that have more than two genders include ancient Greece and Rome, which accepted cross dressing; India, where another gender known as Hijiras dress as female but do not consider themselves male or female; and "two-spirits" in many Native American cultures. Because social science theory is so overwhelmingly influenced by the dual conception of sex and gender, these multiple gender categories have been variously described as being neither male nor female, being a combination of both male and female, or some "in between" conceptualization. Progressive theorists, however, feel that these ideas miss the mark.[4,5]

Further, the gender roles for any particular culture, population or community have not necessarily been static throughout history, as all cultures and communities interact and are influenced by other cultures and communities with which they come into contact. For example, the acceptance of alternate gender roles in Native American communities has not been absolute across all tribes, nor static across time.[6]

Furthermore, it is also important to recognize that gender is fluid across a person's lifespan. For example, young people begin to particularize their gender roles very early on in life and, as they reach puberty and adolescence, some may come to understand that their gender does not conform to conventional gender roles. This often occurs in conjunction with an examination of their sexual orientation.

Those who work with and study adolescent sexuality and gender articulate several stages in the coming out process for adolescents. During this fluid, coming out process, Gilbert Herdt asserts that young people with same-sex sexual experiences who behave in more gender "unconventional" ways move through these stages more easily than those who conform to traditional gender role expectations and those who have had heterosexual sexual experiences.[7] Yet, Herdt also notes that this process can be very difficult for racial/ethnic and religious minority youth because of the conflicts they experience with their central [racial/ethnic or religious minority] identity.

In contemporary society, work to understand and support transgender individuals has helped move the conceptualization of multiple genders forward. Transgender persons experience their gender as incongruent with their biological or anatomical sex and may pursue their gender expression through their external behavior and presentation.[8] Activism by transgender persons and queer theorists has helped open up the idea that gender is not static or binary and that there are many ways to think about gender and gender diversity.[9,10] Indeed, in its materials, the Human Rights Campaign talks about the coming out process, both for gender identity and sexual orientation, as a process that can happen at any time along one's life course.[11]

The impact of so-called "gender unconformity" can be particularly devastating in terms of negative health impact, including risk for HIV and other STDs.[12,13] Both sexual minority youth and transgender persons often face considerable stigma and violence, lower self esteem and, in some cases, social marginalization that can impact risky behaviors (e.g., survival sex, unsafe injection practices, etc). The pressure to conform

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to traditional dual gender roles and the generally assumed concomitant sexual orientation is often so great for those whose identity does not conform that they have difficulty accessing services. Discrimination by providers is a major factor. "Lack of understanding and discriminatory treatment of two-spirit men creates an environment where HIV/AIDS can spread unimpeded. Discrimination against two-spirit men discourages them from seeking medical services, especially where there are concerns about personal treatment and confidentiality."[14] To this end, prevention programs that fail to account for the different concepts of gender and the different ways that people categorize themselves risk missing those individuals who may be at highest risk for the disease.

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At a Crossroads: Past and Present Native American Gender Identity, Sexuality and HIV Implications
By the National Native American AIDS Prevention Center (www.NNAAPC.org)

For centuries, Native American tribes had complex social systems, languages and social orders that were unlike European cultures. Many of these tribes included women and traditional middle-gender persons who were fully integrated into the society and, in many cases, often held respected roles within the culture. European contact and colonization destroyed many of these systems. In particular, it negated the roles that women and middle-gender persons played within Native societies. Furthermore, it created stigma and shame around both gender and sexuality within the entire tribal community, fostering a legacy of sex negativity and silence, regardless of gender and sexual orientation.

Rooted in the movements of the 1970s and 80s, there was a re-birth of pride among Native Americans in traditional multiple-gender histories within Native societies as cultural elders and teachers shared language and traditions that reflected their uniqueness as well as the many contributions to their tribal social structures. During this time, Native people who were called homosexual, gay and lesbian by mainstream society began to relearn and reconnect to the cultural traditions of their middle-gender ancestors.

In 1990, at the third International Gathering, a Native gay and lesbian conference in Winnipeg, Canada, the term "Two-Spirit" gained recognition among Native participants to describe middle-gender Native persons and/or other traditional Native genders outside of the European binary system of male and female. It rejected the culturally inappropriate term, "berdache," a European-based term referring to the male cross-dressing slaves in Persian society, which had been used anthropologically to describe middle-gender Native persons. "Two-Spirit" allowed Native people to identify themselves.

The term Two-Spirit is used to connect the Native American roles and identities of the past and present, including contemporary Native American individuals who may identify as gay, lesbian, bisexual, transgender, queer or intersex (GLBTQI), identify as Two-Spirit, or both. Importantly, this term encompasses transgender and other gender-variant identified Native people (e.g., genderqueer, butch, fem, cross-dresser, etc.). As these are newer terms, some Native people do not identify as GLBTQI or Two-Spirit, but identify as their specific traditional tribal gender term. Furthermore, there are Native people who do not identify as GLBTQI or Two-Spirit but engage in sexual or gender-variant behaviors that are categorized by the contemporary terms of GLBTQI or Two-Spirit.

The community health consequences of such a significant change in the cultural worldview and associated norms can be devastating and are difficult to fully understand. The bullets below are some of the public health implications of such a significant change and are meant as suggestions for service providers to consider when working with Native clients.

- Some Native people do not identify as GLBTQI or Two-Spirit but may engage in risky sexual behaviors, leaving them unidentifiable by service providers and without the education and support to reduce their risks.
- Strengths and protective factors related to the integration of Native identity and GLBTQI and/or Two-Spirit identity (self) may exist or be cultivated to reduce an individual's risk.
- Lack of the western, contemporary "coming out" process or "out" existence should not be labeled or shamed without a complex understanding of the cultural context in which an individual is embedded.
- The post-colonial legacy of stigma and shame around gender and sexuality may lead Native communities to reject or ostracize GLBTQI and/or Two-Spirit Native people, which can lead to many social factors that put them at-risk for disease.
- Many GLBTQI and/or Two-Spirit Native people migrate to urban areas to gain acceptance by urban GLBTQI and/or Two-Spirit communities, which may be a source of strength and liberation. However, it may also create a disconnect from their Native cultural roots that may lead to risky behavior.
- Some reservation, village and rural Native communities have not been provided the resources to educate their communities around HIV/AIDS, hepatitis C, STDs, risk factors, risk reduction techniques or GLBTQI and/or Two-Spirit Native People and related identity, community and health and wellness issues.
- Due to the legacy of colonization and the effects of Post-Traumatic Stress Disorder (PTSD), many Native community members suffer from health issues (mental health issues, alcohol and/or substance

use and abuse, diabetes, etc.) that may take precedence over their HIV status and/or exacerbate their HIV risks.

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International Efforts to Address Gender Inequalities: HIV Prevention through Structural Interventions

Nearly 50 percent of infections worldwide are among women. In many countries, there are now, proportionately, more women infected than men. Biological differences between men and women that facilitate transmission of HIV contribute to the disproportionate impact of the epidemic on women. In many developing countries, cultural, structural and economic factors are equally important in driving the epidemic among women. Such factors structure and reinforce power inequalities between men and women in all spheres life, including those which are sexual. Such factors include:

- Social norms that allow and/or encourage men to have many sexual partners while at the same time discourage women from sexual activity until marriage.
- Lack of access among women and girls to basic education about their bodies, health and illness and disease prevention. Women often enter marriage not understanding reproductive health or how to protect themselves, increasing their vulnerability to disease, including HIV.
- Lack of property rights and access to employment or other means of economic self-sufficiency among women, making them economically dependent on men.
- Violence against women (physical, sexual and emotional), which is culturally acceptable or tolerated, increases women's vulnerability to HIV/AIDS. Fear of violence can prevent women from learning and/or sharing their HIV status if they are positive.

A typical story for a woman living in Sub-Saharan Africa might be that she is forced into marriage at a young age with an older man who may have several sexual partners. She is forced into sex with her husband and unable to insist on the use of condoms. Subsequently, she is infected with HIV by her husband, and, as a result, is accused of adultery and of bringing HIV into the relationship. For this, she is banished from her home and family. Lacking independent financial resources, an education or access to employment, her only option is to turn to the sex work that fosters continued transmission of HIV. If she is able to stay within the family, she is often expected to continue to assume a major portion of the responsibility for upkeep of the household and care of the family. When she eventually becomes ill, these critical functions will not be attended to and her family begins to collapse. Because her story is so common, it will lead to the collapse of entire communities.

International HIV/AIDS efforts are beginning to acknowledge that gender inequity is not so much a result of

the HIV pandemic as it is an intrinsic cause of it. Biomedical and structural interventions that seek to empower women by addressing inequitable social norms and structures are critical to address this issue.

No description of models for empowerment of women in combating HIV is complete without a discussion of microbicides. Microbicides are a substance in the form of a gel or suppository that can reduce the likelihood of HIV transmission when applied within the vagina, while allowing for the possibility of pregnancy. It is estimated that a 60 percent efficacious microbicide used by 20 percent of women in 73 low income countries would avert 2.5 million HIV infections over three years.[1] Research trials are currently being conducted and it is estimated that widespread access to microbicides is feasible within this decade.

Government reforms to change legal structures affecting women's property rights and promoting land titling are critical to economically empower women. Collective approaches to property acquisition and agricultural production are one such example of legal reforms. In such an approach, women collectively purchase or lease land as well as improve and manage it.

Microcredit is another structural intervention designed to empower women. Microcredit refers to the extension of very small loans to poor entrepreneurs who are unable to obtain traditional loans or credit. Several studies have demonstrated that economic and business skills acquired through microcredit schemes translate to improvements in self-esteem, larger social networks and wider control over household decision-making. At the same time, research on the health and social impacts of microcredit schemes has shown improvements in the nutritional intake and educational status of children and a greater likelihood of contraceptive use among participants as compared to control groups. These impacts have even been shown to "diffuse" throughout the community and to lead to more widespread improvements in specific community health indicators.

Other structural interventions that are showing success in addressing gender inequity are community mobilization efforts. These interventions move beyond a framework within which men are identified as the "problem" and begin to think of the gender inequity problem as one that affects men as well as women. There are several such programs currently operating throughout the world. One example, drawn from South Africa, is the "Men as Partners Program (MAP)." MAP is based on three related elements of constructive male involvement: first, that current gender roles often give men the ability to influence and determine the reproductive health choices made by women; second, that current gender roles also compromise men's health by encouraging men to equate a range of risky behaviors with being manly, while encouraging them to view health-seeking behaviors as a sign of weakness; and third, that men have a personal investment in challenging the current gender order for their own health as well as for women placed at risk of violence and ill-health by these gender roles. The MAP program involves the implementation of educational workshops with groups of men and mixed-sex audiences. The workshops involve a variety of interactive educational activities used to explore issues associated with the three elements.

While women in the United States have greater access to education, employment and economic and social rights than women in many other countries, and while they also benefit from technological and social advances that alleviate the unremunerated work they do to support their families, the differences in terms of gender inequity tend to be a matter of degree rather than substance. Research shows that it is the American women whose lives most reflect those in sub-Saharan Africa – women of color and women living in poverty -- that are most at risk for HIV in the U.S. Like their African counterparts, U.S. women with HIV face limited access to care and experience disparities in access relative to men. We in the U.S. need to begin to understand the extent to which gender inequity is driving the U.S. epidemic and have the courage and vision to modify, adapt and implement the broad structural interventions that are already showing success in the rest of the world.

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Examining the Epidemic among African American Women through the Lens of Gender
To better understand how issues of gender have contributed to the disproportionate rates of HIV infection among African American women, NASTAD interviewed federal and health department leaders.

Interview with Janet Cleveland, Deputy Director for Prevention Programs, Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention

NASTAD: *Why are we seeing rising rates of HIV infection among women, particularly African American women in the U.S. and what forces are contributing to this rise?*

Cleveland: It's important to note that this epidemic is extremely complex and has evolved and expanded to impact diverse populations. Today, the most disproportionately impacted population is African Americans. We know that almost one-half of the estimated number of persons living with HIV/AIDS in the U. S. (in the 33 states with confidential name-based reporting since 2001) are Black; and with Black females in particular, we know that they have an HIV infection rate more than twenty times that of white females and four times that of Hispanic females. These trends are alarming and important to consider while also examining some of the underpinning issues driving the epidemic among women. Why is HIV now the leading cause of death among Black women aged 25 – 34 years? I want to be very clear in saying that race itself is not a risk factor for HIV. However, it is important to acknowledge how race and morbidity are intertwined in how we discuss this issue. There are historical, societal and cultural realities for many African Americans that may lead them to face greater challenges and vulnerabilities as it relates to acquisition of HIV. We know that poverty, lack of access to quality healthcare and education and high rates of sexually transmitted infections place many African American women at risk for HIV. We also know that economic disparities may lead to risk behavior such as trading sex for money, food or shelter. For many African American women, it comes down to a hierarchy of need, and supporting their families may oftentimes supersede their ability or willingness to make the right choices about their own health. On another note, there is still a great amount of stigma that is associated with HIV within the African American community, oftentimes making it difficult for women to have authentic discussions about sexual risks and risk-taking behaviors. As I stated before, this issue is very complex when it comes to women and we cannot discuss the issue of women and HIV without considering the whole woman.

NASTAD: *How do power dynamics and the socialization of women in the U.S. contribute to the rise in infection rates?*

Cleveland: I recently heard a presentation at CDC where the presenter discussed the role of power and gender as it relates to HIV. The presenter started his presentation by reminding the audience of a saying that many of us grew up with, "Little girls are made of sugar and spice and everything nice and little boys are made of snakes and snails and puppy dog tails." From the time that we arrive on this planet there are distinctions made based on gender. Many girls are still raised in very gender-specific ways in which we're taught and socialized to take on multiple roles, caring for everyone else – oftentimes at the expense of not taking care of ourselves and our own health needs. We have to provide for our families; we are mothers, wives/partners, daughters, sisters…not that men do not have multiple roles in this society…but, certainly, women far more often find themselves being everything to everybody. Black women, in particular, have faced challenges around gender and power that date back to the early history of slavery in this country. So from the start of our existence in America, Black women have oftentimes diminished themselves because of the roles that they have been expected to play. Although there are countless African American women who live successful lives that include making healthy decisions about their life and their health status, there are those women who, in addition to facing the cultural norms and expectations about the role of a woman in the Black community and in the larger society, have found themselves in a position of economic instability and dependence, which can lead to engagement in certain risk behaviors.

I believe that issues of power and gender are integral to conversations about HIV. As we continue to have discussions about HIV among African American women, issues of abuse – domestic, sexual, childhood trauma – are continually raised, which all relate to power and powerlessness. Many women of all races feel uncomfortable having conversations with their male partners about sex and sexual practices, monogamy

and condom use. All of these issues continue to play into how empowered a woman is in protecting herself against HIV.

***NASTAD**: What are the highest priorities related to addressing the HIV epidemic among women in the U.S. and discuss how CDC is responding to these priorities.*

Cleveland: From CDC's perspective, our main priority is to continue to provide access to proven interventions targeting women. In regard to African American women, we're doing some different things in terms of looking at what our comprehensive prevention approach should include. Working with health departments is certainly a huge component of how we do our work, as is working with our community partners. We're trying to expand our focus to further examine issues of social networks and co-morbidities such as substance use and mental health. We're also testing social marketing campaigns that specifically focus on African American women. There has been an overwhelmingly positive response to the intervention, SISTA (Sisters Informing Sisters About Topics on AIDS). We're also rolling out two additional interventions for African American women - WiLLOW (Women Involved in Life Learning from Other Women) and SiHLE (Sistas Informing, Healing, Living, and Empowering). We're trying to increase our efforts to get proven interventions targeting all populations into the field. We're also convening workshops with hospitals to help implement rapid testing in their labor and delivery and emergency departments. To add a little more to the testing piece, we're examining ways to ensure that rapid testing is administered to African American women in a manner that is culturally appropriate and are examining new venues in which to conduct tests. Overall there is a broad range of activities that we are involved in and are definitely trying to strengthen our partnerships and connections to help us to address the HIV related stigma that still exists in African American communities.

***NASTAD**: How can health departments strengthen their work with CDC to better address these priorities?*

"Women in leadership roles have an opportunity to bring visibility to and speak to gender-related issues in a way that others may not be able to do. That personal perspective and reflection offers an invaluable opportunity to educate people about women-specific issues that they may not be as familiar with or as appreciative of."

Cleveland: Health departments play a critical role in helping us to address these priorities. I'm excited by the work that NASTAD has done in conjunction with your African American Advisory Committee to bring increased focus to the issue of HIV among Black women, because that is going to help broaden the discussion on a national level. I'm also excited about our continued public health partnership with the health departments in the 65 jurisdictions. The work that happens at the state/local levels informs the national landscape and what our prevention directions are at the national level. CDC is reliant on health departments to continue to provide us information, to continue to feed us with the data, so that we can understand what is happening in local areas. This helps us to frame how we address the epidemic from a national perspective. It is essential that health departments continue to appropriately focus programs and resources based upon their local epidemiological profiles. We must continue to be strategic and efficient in targeting and prioritizing our prevention programs and services to those populations most impacted, especially in times of constrained resources. Additionally, I believe it to be essential that health departments, CDC, CBOs (community-based organizations} – the HIV prevention workforce in general – must all continue to actively seek community input from those infected and affected by HIV in order to strengthen our programs and package them in a way that is relevant, meaningful and effective.

***NASTAD**: In light of the fact that there is female candidate running in the 2008 presidential election, what role(s) do women in leadership positions play in influencing gender based health prevention policy and*

programs?

Cleveland: When I first read this question I reflected back on what my role as a woman leader in HIV has been over the years. I think that anyone who knows me recognizes that I'm passionate about addressing the HIV epidemic among all populations. However, a great deal of my work even prior to my coming to the CDC has been focused on the issue of women and HIV. I've tried to help ensure that the issue of women and HIV has been an important consideration within our overall HIV prevention efforts. I do believe that each person brings who he/she is as an individual to the various roles that we play in life, and most certainly that applies to the workplace as well. But more importantly, I come to this job as a public health professional trying to do the best that I can in my contributions to addressing the epidemic across the nation. Still, I can never deny the fact that I am an African American woman and certainly bring my life experiences to the work that I do each day. Women in leadership roles have an opportunity to bring visibility to and speak to gender-related issues in a way that others may not be able to do. That personal perspective and reflection offers an invaluable opportunity to educate people about women-specific issues that they may not be as familiar with or as appreciative of. Being in a leadership position, regardless of gender, brings with it not only opportunity, but also great responsibility.

Interview with Kimberley Dobson, Acting Section Co-Director, Acting Prevention Director, Georgia Department of Human Resources, Division of Public Health, Prevention Services Branch, HIV Section

NASTAD*: What have been some of the issues you've encountered with community, planning groups, or within your health department, when seeking to address issues related to gender and HIV/AIDS risk?*

Dobson: One of the issues that we've faced is both the perceptions and realities related to HIV rates among African American MSM (AAMSM), which perhaps speaks more to sexual orientation rather than gender. AAMSM in Georgia, as in the U.S., have been severely impacted by the epidemic and because of the incredibly high rates of infection among this particular population, African American women have sometimes felt that they have had to take a back seat in terms of recognition. AAMSM across the country have been very vocal champions and advocates around their expectation that funding allocated to their population be reflective of the trends in the epidemic. Here in Georgia, we've worked hard to ensure that funding does follow the epidemiological data and have worked closely with our funded grantees to ensure that they are delivering appropriate services to AAMSM. However, I think that over the past few years we've not given adequate attention to African American women. While we are able to fund more programs for African American women than many other populations, increased attention is necessary to better understand African American women and their unique realities as well as to determine whether or not the services we are providing are appropriate and effective. Let me be clear, increased attention to African American women should in no way be translated to mean less attention to AAMSM or any other population at risk for HIV. Inadequate resources sometimes demand an "either/or" approach as opposed to "both/and." This is unacceptable. We need more resources to adequately address the needs of African American women and AAMSM, as well as all populations at-risk for HIV infection.

NASTAD*: How has Georgia segmented your population in terms of targeted prevention efforts and what challenges have resulted in addressing these prioritized populations?*

Dobson: One of the issues that stands out in terms of AAMSM is homophobia, which is very pronounced considering that we are located in the Bible Belt. African Americans in this area, regardless of sexual orientation, socio-economic status, etc., are very spiritual and come from deeply religious backgrounds. Many of the risk behaviors that we see playing out among AAMSM are perceived as being in conflict with the teachings of the church. As a result, conversations about HIV remain shrouded in stigma, homophobia and what people view as immoral sexual activity (including sexual relationships between men and women having multiple sexual partners). This in turn keeps dialogue about how to address HIV in our communities underground. Therefore, people who we in public health would term at-risk or high-risk are reticent to participate in prevention programs and services, access treatment or share their HIV status because the conflict around the behaviors that are putting them at risk may jeopardize their ties to their community, their church, their God. Although Georgia has a strong history of civil rights and social justice movements, this activism has not been translated to gay rights or to the rights of women to own their sexuality rather than be subjected to prescribed gender roles. We recently have seen some positive developments, for

instance, the Southern Christian Leadership Council/ Women's Organizational Movement for Equality Now, Inc. (SCLC/W.O.M.E.N.) has hosted several conferences and meetings that include discussion about various issues of women and HIV. So things are changing, but stigma and homophobia still play a huge factor in our ability to effectively reach both African American women and AAMSM.

NASTAD*: How do you think that being situated in the Bible Belt impacts gender roles?*

Dobson: This can definitely be seen playing out in the socio-cultural realm. In the South, African American women bring a deeply entrenched history of oppression. At the end of the Civil War, Blacks were brought out of slavery and found themselves in the peculiar position where white males were still "at the top." In addition, white women were viewed as being above Black men, who were, in turn, restructured so that they were on top of/dominating their own women – ultimately leaving Black women at the bottom of the proverbial totem pole. We have a socio-cultural and institutionalized history which is incredibly difficult for marginalized African American women to work their way out of, and which inextricably shapes gender norms, roles and expectations in our communities.

NASTAD*: Describe in detail a specific program/initiative that stands out as a success story in the efforts of the Georgia health department to address issues of gender.*

Dobson: I am really proud of a social marketing campaign which we hope to roll out in late Fall of this year. The health department felt it was very important to go back into various communities to find out from women what they believed to be the main problems related to HIV in the African American community and HIV among African American women. We also asked these women what they had learned about HIV, what they believed the risk factors to be for African American women and what meaningful messages should be crafted to reach them and their sisters. We really took our time to conduct focus groups, surveys and key informant interviews with people who provide services to African American women and, more importantly, to a diverse range of consumers in terms of age, education, drug use, socio-economic status, etc. We were deliberate in doing our homework because, although the majority of African American women are subjected to similar challenges of racial and gender discrimination, we recognized that they are not a monolithic population. We are now working with the data that we've compiled and are crafting messages to take back to the women to determine if they resonate. These messages will address issues such as condom negotiation, accessing counseling, testing, health education and risk reduction services and getting into care and treatment. Some of the preliminary factors that the women have attributed to their risk include lack of power in their relationships, issues with low self-esteem and living in a male-dominated society. Also, many did not personalize risk because they were in a committed relationship and didn't think that these issues impacted them. We found that many of the women that we spoke with had a high level of intellectual understanding about HIV but also had a high level of detachment and didn't feel that HIV "was them" or impacted them. The feedback that we've received from these women has been invaluable. As far as we're concerned, they are the experts – not us.

NASTAD*: What lessons have you learned in your work, and what recommendations do you have for other health departments seeking to do this work?*

Dobson: The primary challenge we faced in terms of launching the social campaign was around scheduling the women. However, once we were able to arrange a time for participants to meet, things unfolded beautifully. The participants expressed an overwhelming amount of gratitude to have been brought together in solidarity with other women to discuss issues that impacted their lives on a daily basis. If I were to recommend anything to health departments seeking to implement similar social marketing campaigns, it would be to incorporate as many community partners as possible – both traditional and non-traditional. We were able to assess the attitudes of the African American women in the community, but I think it would probably also be helpful to assess the attitudes of your community partners. It's the attitudes of partners, coupled with the voices from the community, that really help you determine what direction you need to move in terms of addressing this epidemic among African American women and African American communities as a whole.

Hot Topics in Gender Research

To better understand the socially constructed challenges that arise when trying to implement effective HIV prevention for both men and women, NASTAD interviewed two leading researchers.

Interview with Ralph DiClemente, Associate Director of Prevention Science at the Emory Center for AIDS Research (CFAR) and Co-Director of Graduate Studies at the Rollins School of Public Health, Emory University

***NASTAD**: Please describe the difference between gender and sex. How do gender and sex influence sexuality differently?*

DiClemente: Sex is a biological term – male/female – a term about which, unfortunately, we don't have much say. But certainly gender and how people respond to men and women is socially constructed. The social construction of gender includes the roles we attribute to both men and women. Aspects of these roles are what actually drive risk behavior and create a risk environment. For example, a characteristic of women's roles is being less demanding of their partners, including women who are married. Any indication or suggestion by a woman that their male partners use condoms can be misconstrued as mistrust, as opposed to a gesture towards "let's be healthy." Gender bias obviously exists in sexual relationships. For instance, engaging in sexual activity with multiple partners seems to be more condoned among males but is often sanctioned among women. So, many of the same behaviors are not treated the same way for men and women, nor are they perceived in the same way. There is certainly more bias attached to women in this example. Other areas of imbalance include levels of independence and autonomy, as well as the perception that women play a supporting role in relationships, whereas men are viewed as the head of the household. We still live in a patriarchal society, with women often being thought subservient to men. Clearly the idea that women are subservient carries through various aspects of women's lives, beyond just romantic relationships, into the workplace and issues of equal pay, as well as into access to health care. In many instances, although women may have achieved economic independence, it is still frowned upon to be more powerful than a male partner – women may have "come a long way, baby," but not in this relationship.

***NASTAD**: Describe the Theory of Gender and Power, briefly highlighting why you find it a useful framework for HIV prevention interventions.*

DiClemente: The Theory of Gender and Power (TGP) was developed by my wife, Gina Wingood, and me. The theory was originally a sociologic theory that came from Australia and was never really applied to intervention research, nor was it meant to be. Gina decided that this theory would be good way to understand women's risk for HIV because of its three main constructs: economic imbalance, emotional attachments, and power imbalance in relationships. These three constructs or domains are applicable at the individual, institutional and societal level. An example of how these constructs play out at the institutional level would be looking at why more men veer towards the sciences and math than women and how colleges treat them in their academic pursuits.

Examining the media helps us to understand how these constructs also manifest at the societal level. A perfect example would be looking at how women are portrayed in rap videos. Unfortunately, not only do these videos influence the way men treat women, they also influence the way women expect that men will treat them. In our studies of young women who spend extensive amounts of time watching rap videos, the young women reported that the videos reflected "the way that things are in the real world." So the media is truly an interesting phenomenon and pervasive influence that impacts gender relations. I often think about whether media drives culture, reflects culture, or is creating a culture for us. Reflecting back to the three domains of TGP – economics, emotional attachments and power – I want to clarify that, in this instance, power means the ability to affect change in a relationship. Power is not a negative term. Everyone's got power to some degree, so your power in a relationship includes the implements that you have to affect the relationship. However, many women lack sufficient power in relationships, which can be seen as a derivative of the first two constructs of economics and emotional attachments.

***NASTAD**: You've spent a significant amount of time discussing the media. How would you suggest that we leverage the influence of the media with some of the theoretical information that has emerged from studies or interventions addressing gender and seeking to empower women?*

DiClemente: What Gina and I did was to look at what had been done in the area of prevention for young

African American women, a group disproportionately impacted by the epidemic from the get-go. We recognized that many of the prevention programs that had been developed were very rationally-based, provided general information and skills building and emphasized attitude and norm change. We felt, however, that this wasn't necessarily optimal and decided to take a different approach. Using TGP as a framework, we started to question how we could get young women to: a) feel powerful; b) be powerful; and c) use their power constructively to affect their relationships. So what we did was to create interventions that focus on emphasizing and amplifying racial and ethnic pride. These interventions – Women Involved in Life Learning from Other Women (WILLOW) and Sistas Informing, Healing, Living, and Empowering (SIHLE) – which CDC has adopted for national dissemination through their DEBI project, don't focus exclusively on HIV and STDs but rather seek to get the participants thinking about questions such as, "Who is an important role model in your life?," "What are their characteristics?" and "Why would you like to be like them?" There's a theme that runs through these interventions that encourages participants to "be safe for yourself, your family, and your community." This is a concept that many young women had never considered, and it is not being heard in the media. Our interventions help participants recognize that they are a part of a greater whole, not simply what the media portrays. Further, our interventions seek to help participants recognize that they are powerful, and that, although it's necessary to "protect yourself," young women also have a certain amount of responsibility to their family and communities.

Articulating this message to participants can be achieved through various activities. For example, one activity designed to address the negative images of women in the media includes watching rap videos without sound and then reading aloud the words of the videos. Once participants read the words, rather than just singing along to the song they often become incredibly offended. For many participants, this experience is not only striking on a cognitive level but also on a visceral level. Not only do we point out the negative images of women, but we encourage participants to identify positive images and role models. Oprah Winfrey always emerges at the top – right behind their moms, who are often described as independent, proud and strong.

NASTAD: *Prevention interventions grounded in the TGP strive to "empower" women – what does empowerment mean and are their gradations of empowerment or is one either empowered or not?*

DiClemente: I certainly think that there's a continuum of power and that power is not a monolithic quantity. For example, you may have a great deal of power at work but when you go home to your husband you have very little power. So although someone can be empowered, this doesn't necessarily translate to all spheres and domains of life. Again, in TGP power refers to the ability to affect or influence change within a relationship, be it romantic, familial or a friendship.

NASTAD: *How do other social and cultural factors such as ethnicity, class, socio-economic status and education influence or mediate gender-based inequalities as they relate to sexual risk for HIV?*

DiClemente: There's still a lot to do in this country to address gender discrimination. If we overlay this with racial discrimination, we're facing a "double whammy" with the intersection of race and gender. We've recently completed a study examining the issue of gender discrimination, racial discrimination and health outcomes. The data has been collected and we're currently analyzing the data and hope to have some findings within the next three months.

When examining issues of risk behavior and HIV, we must recognize that a lot of things override the impacts of socio-economic status or education, which one could blindly assume would decrease levels of risk behavior among women. Culture really is a pervasive variable in sexual risk-taking behaviors that have both positive and negative impacts. In terms of gender and risk, I think that many women (not all) are in constrained relationships where the biases that we talk about on a broader macro level are certainly apparent. These relationships are often times gender imbalanced irrespective of education, class, race or ethnicity.

Interview with Richard Parker, Professor and Chair in the Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University

NASTAD: *How are gender and sexual identity related?*

Parker: Gender and sexuality are related in a variety of ways. For a long time, in both society and research, the two were really conflated as if there was no difference between them. Males and females were assumed to have a natural sexuality based on their gender. The most recent waves of contemporary feminism, from the 1960s through 1980s, challenged this notion. Gender is, in fact, the cultural elaboration or construct of notions of masculinity and femininity and is not biologically grounded. Men and women behave differently across the globe depending on the rules of the society in which they live that tell them how to be a proper male or female. One of the first things that feminist thinking did was separate gender from sexuality and assert that, although the two are closely related, there are also distinct hierarchies in gender and sexuality. Power and equality function in relation to gender as well as to sexuality. Analytically, it's really important to be able to take this apart to be able to understand how relations of power and inequality work in terms of both factors. A concrete example would be that women are oppressed by virtue of the gender hierarchy which gives power and control to men and makes it difficult for women to negotiate sexual relationships and safer sex. However, "non-normative" sexualities, men who have sex with men (MSM), transgender individuals or women who have sex with women, are also oppressed and subjected to unequal power relations by virtue of their sexuality.

NASTAD: *In what ways are gendered inequalities in power expressed in relations between men (i.e., MSM/ gay/transgender) and how is this expression unique in comparison to relations between men and women?*

Parker: There definitely are huge power inequalities between men that can clearly be seen terms of men's non-normative sexualities. Men who are effeminate, for instance, transgender individuals who may be biologically male but adopt a female persona, will often be subjected to the same kinds of gender oppression that face women. An example of this would be that in many societies, particularly in Latin American countries where I conduct a lot of my research, a wide-spread cultural pattern is to organize same-sex relationships (between both men and women) along notions of masculine activity and feminine passivity. Two males in a same-sex relationship, depending on who is the active (i.e., penetrating partner in sex), and who is the passive (i.e., penetrated partner), function within a specific set of relationships and power domination. The active male in a same-sex relationship doesn't necessarily identify himself as homosexual, gay or even bi-sexual by virtue of his interaction with another male. The penetrating partner often views his behavior as "doing what males do," or having sex with as many partners as possible wherever he can find it. So there is not a lot of stigma or shame associated with activity in male sexual relationships. On the contrary, the passive, or penetrated partner, is seen to be emasculated, as if his masculinity has been sacrificed because of the sexual relationship. The penetrated partner is oftentimes seen as being inferior, almost as a symbolic female. So, the gender inequality seen between men and women gets reproduced in relationships between two men. Just as it is more difficult for women to negotiate safer sex, condom use or oral contraceptive use, the passive male partner finds himself in the same position as women in heterosexual relationships. A footnote is that the same active/passive dynamic is often seen played out in lesbian relationships.

NASTAD: *From the perspective of HIV prevention, is it more useful to think about gradations of power/ empowerment which are contextual and situational? How might we apply this to prevention efforts?*

Parker: Empowerment is a key prevention strategy for allowing individuals in positions of vulnerability to move out of their situations and acquire the necessary power to negotiate more equitably in all sorts of relationships. Over several decades of research on the epidemic, we've seen clearly how HIV infection is driven by power inequalities in terms of gender and sexuality, but also in terms of economic inequality, poverty, racism and ethnic discrimination, and even in terms of age differentials. The HIV/AIDS epidemic has basically moved along the fault lines of inequalities in every society. Almost everywhere, you find that the epidemic concentrates itself where multiple forms of inequalities overlap to create a synergy – sometimes described as a syndemic – because of the crossing of gender power differentials, race and ethnicity, etc. So poor women who are from ethnic minority populations are primary targets for the epidemic in a way that they would not be if those inequalities didn't overlap to create that synergy. Inequality is a driving force in the epidemic and gender inequality has been especially pronounced. AIDS in many societies was first noticed in populations of MSM but quickly moved into the heterosexual population. In terms of the epidemic, women's vulnerabilities are enhanced because of their lack of power and being in inferior situations economically often leaves them in a position of not being able to negotiate safer sex.

NASTAD: *If resources were not a barrier, what would you do to address the HIV epidemic in the U.S.?*

"The HIV/AIDS epidemic has basically moved along the fault lines of inequalities in every society. Almost everywhere, you find that the epidemic concentrates itself where multiple forms of inequalities overlap to create a synergy – sometimes described as a syndemic – because of the crossing of gender power differentials, race and ethnicity, etc."

Parker: Over time, the epidemic in the U.S. has become concentrated in certain pockets of poverty and populations that are profoundly marginalized within our society. The kinds of programs that we need are those that don't concentrate solely on the HIV epidemic but on the broader sets of social circumstances that marginalize communities and populations in ways that make them vulnerable to HIV. It's important for us to recognize that even if we had unlimited resources, there would always be limits to what public health and prevention can do. We recognize that inequalities drive the epidemic and that public health initiatives cannot distinctly put an end to inequality. What we can do is to develop structural level interventions that do make a difference and provide alternatives to those people who might otherwise not have alternatives, above all else guaranteeing human rights and protection to individuals made vulnerable by negative social forces. How you approach the epidemic really matters and is ultimately as important as the money. If you don't take aim at the broader structural issues you're ultimately doomed to failure. The real lesson of HIV/ AIDS in the U.S. and around the world is that there is no technical solution to the epidemic. Even if we had a vaccine, there would still be no magic bullet to address the social inequalities that are underlying the epidemic and driving HIV transmission.

***NASTAD**: It's hard for people to wrap their heads around structural issues because they seem intangible or insurmountable. What strategies would you recommend for people in the field who are trying to implement structural level interventions?*

Parker: The problems that we face are so huge that they almost become immobilizing. We can't wait for a revolution that will result in everyone living in equality because that would be a very long wait and this epidemic demands immediate action. However, there are concrete things that we can do to make a difference by changing specific structures in which people are operating. Simple steps such as ensuring that there is a bowl of free condoms that are readily accessible, providing low interest loans to marginalized persons to support economic independence, or generating alternative income strategies for women. These kinds of initiatives are not as grandiose as the language that we use to analyze structural level interventions might suggest. It is about small steps to change the environment which people are operating in to give them opportunities to choose safer sex.

We may not be able to change overall structures of poverty, etc., but we can build empowerment in important ways by providing vulnerable populations with choices and tools to be able to protect themselves. Broader initiatives, for instance, comprehensive sexuality education for young people, or ensuring that young people can access reproductive health care, are in our power to do, well before we begin to tackle the large scale inequalities that are driving the epidemic.

Conclusion

The purpose of this month's *Prevention Bulletin* was to examine the impact of gender on the HIV epidemic from various perspectives. Public health practitioners must remain cognizant of the reality and effects of socially-constructed gender roles on our work to prevent disease transmission. Gender constructs present significant challenges to women and men as they attempt to navigate within society and attempt to negotiate sexual relations and risk behavior. We hope we have demonstrated that the implications of

constructed gender roles vary significantly between cultures and communities and influence the lives of both men and women. A common theme that emerged from the stories and interviews is that the unique challenges of gender roles are just one piece of a broader puzzle driving rates of infection among certain populations. Issues of gender, as well as other social and cultural factors including race, ethnicity and class, are inextricably linked and all play a role in the evolution of epidemics in the U.S.

Next month's *Bulletin* will focus on structural level interventions, which, unlike interventions rooted in individual behavior change, seek to impact the environments and/or systems that at-risk populations must navigate.

Meeting and Planning Calendar

Capacity Building Opportunities: For a searchable database of CDC-supported capacity building trainings and events, please visit: the Capacity Building Branch's Group Events Management System site.

September 27-28, 2007
19th Annual Denver STD/HIV Clinical Update, Denver, CO. For more information, call (303) 436-7226; or visit the event website.

October 15, 2007
National Latino AIDS Awareness Day.

November 2-6, 2007
American Association for the Study of Liver Diseases Conference, Boston, MA

November 3-7, 2007
American Public Health Association Conference, Washington, D.C.

November 7-10, 2007
United States Conference on AIDS, Palm Springs, CA.

December 1, 2007
World AIDS Day.

December 2-5, 2007
2007 National HIV Prevention Conference, Atlanta, GA.

December 4, 2007
Michigan Hepatitis C Conference, Plymouth, MI

February 3-7, 2008
15th Conference on Retroviruses and Opportunistic Infections, Boston, MA.

February 7, 2008
National Black HIV/AIDS Awareness Day.

February 25-26, 2008
2008 National Conference on African Americans and AIDS, Philadelphia, PA. Sponsored by Minority Healthcare Communications, Inc.

March 10, 2008
National Women and Girls AIDS Awareness Day.

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March 20, 2008
National Native HIV/AIDS Awareness Day.

March 28-29, 2008
17th Annual HIV Conference, Orlando, FL. Sponsored by the Florida/Caribbean AETC.

May 19, 2008
National Asian and Pacific Islander AIDS Awareness Day.

May 22-25, 2008
20th Annual National Conference on Social Work and HIV/AIDS, Washington, D.C.

July 28-29, 2008
2008 National Conference on Latinos and HIV/AIDS, Miami, FL.

August 3-8, 2008
XVIII International AIDS Conference, Mexico City, Mexico.

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If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact Dave Kern or Lynne Greabell (202) 434-8090. NASTAD's *Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

LET US KNOW WHAT YOU THINK! NASTAD welcomes feedback to issues presented in our newsletter. Submit your commentary to: NASTAD@NASTAD.org.

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