THE INTERDEPENDENCE OF SYSTEMS OF DOMINANCE, PLACE THEORY AND GENDER IN CREATING RISK FACTORS FOR HIV

by

Braden Kyle Linn

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Braden Kyle Linn

This thesis has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

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[redacted]hilip [redacted]
Chair: Supervisory Committee

Approved for the Major Department

[redacted]
Chair

Approved for the Graduate Council

[redacted]
Charles [redacted]
Dean of The Graduate School

ABSTRACT

Existing research in HIV prevention typically focuses on increasing personal agency to overcome risk factors. My research focuses on structural risk factors and policy changes that can help eliminate structural risk factors.

I attribute many structural risk factors—like homelessness, poverty and lack of health insurance—to processes described by Sidanius and Pratto in *Social Dominance*, like aggregated individual discrimination, institutional discrimination and behavioral asymmetry. In examining risk factors in light of Social Dominance Theory, it becomes clear that the source of many risk factors for women and communities of color—for whom HIV remains highly problematic—is inequality.

Additionally, I propose thinking about risk factors in terms of gender, space and power. After reviewing literature that outlines the foundations of each concept, I propose the idea that gender, space and power are interdependent many risk factors contain multiple dimensions of each concept. Each risk factor is discussed in terms of the process that creates it and the dimensions of gender, space and power it contains.

Housing, which has been considered a protective factor for people at risk for and living with HIV, contains dimensions of gender, space and power. Using existing ethnographies, I demonstrate how housing can contribute to behavioral asymmetry. Some women, for example, who rely on male partners for housing tolerate sexual abuse, cheating and drug use in an effort to preserve the relationship and their housing.

However, tolerating the behavior, which meets the definition of behavioral asymmetry, places them at risk for HIV

Richard Wilkinson has demonstrated a positive correlation between equality and health. Using his arguments as a foundation, I propose a system for evaluating policies that both eliminate structural risk factors and move society towards equality. A number of existing policies, most from the United States, that deal with homelessness, increasing the proportion of people with health insurance and calculating public entitlements—among others—are presented.

Although this is primarily a theoretical work, a number of important conclusions can be drawn. The chief ones are that dominance can be linked to HIV, that social policy that promotes equity may have an impact on the numbers of new HIV cases and that housing should be considered both a potential risk factor and a protective factor.

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INTRODUCTION

The number of new HIV infections in the United States has remained relatively unchanged—and has in fact increased—in the recent past. Epidemiology indicated that women and communities of color bear a disproportionate burden of disease (Prevention October 2008). While some research exists that explains the discrepancy, scholarship has not yet fully explored the roles of gender, space and power in risk factors for HIV.

This thesis examines risk factors for HIV in the context of Social Dominance Theory. Published by Sidanius and Pratto in *Social Dominance*, Social Dominance Theory is an account of the way hierarchy is established and maintained between groups (Sidanius and Pratto 1999). In thinking about risk factors in this way, it becomes apparent that hierarchical social stratification is the source of many structural risk factors for HIV and that women and communities of color are on the subordinate end of systems of dominance.

To clarify how stratification exacerbates HIV risk, I provide a conceptual framework that elucidates the roles that power, gender and space play in strengthening aspects of social dominance. I further contend that an understanding of these interdependent relationships can help construct a framework for evaluating policy responses to mitigate HIV risk factors. The framework I envision shows how gender, space and power are inherent in HIV risk factors such as sexual inequality, homelessness

income instability and housing dependency as well as how these elements can interact to strengthen social subordination. Thus the conceptual framework helps explain how complementary policies—both behavioral and structural—can lower health risks associated with desperately subordinate social status.

This thesis integrates knowledge from a variety of fields, including sociology, social psychology, public health, urban planning, public policy, and feminist studies and gender studies. The interdisciplinary nature of this paper underscores the need for a comprehensive, transdisciplinary, multicausal approach to altering the course of the HIV pandemic in the United States.

Structure of the thesis

The first half of this thesis consists of a literature review which highlights the need for action through a discussion of HIV epidemiology and existing policies. Later, an introduction to the concepts that form the theoretical underpinnings of this paper is presented.

This second half of this paper aligns risk factors for HIV with three kinds of dominance explained by Sidanius and Pratto-aggregated individual discrimination, institutional discrimination and behavioral asymmetry. These represent, if you will, the collective effects of interpersonal acts of discrimination, the discriminatory acts of institutions through their rules, policies and regulations, and the self-defeating behavior that accompanies the psychological internalization of one's own subordinate status. Each of these three kinds of social dominance is headlined in sections below. Within each

section, one finds a discussion of how gender, space and power affect HIV risk factors. Each section concludes with a discussion on ways to reduce the three forms of discrimination Sidanius and Pratto describe with policies that promote equality in the dimensions of gender, space and power. I hope to accomplish two things by arranging the thesis this way. First, I hope to make clear that the domestic HIV pandemic is exacerbated by systems of social dominance. Second, I hope to show that HIV risk factors incorporate aspects of gender, space and power and that public policy responses can be evaluated based on their ability to dampen the structures of social domination.

RECOGNIZING THE CAUSE FOR ALARM: HIV EPIDEMIOLOGY

The difference in rates of HIV among ethnic groups, sexual identities and economic classes is alarming. I am principally concerned with the high numbers of infections among the most marginalized in the United States. As such, a review of HIV epidemiology is appropriate. The following data are from Centers for Disease Control and Prevention (CDC).

As of October 2008, there are an estimated 1,106,400 persons living with HIV infection or an AIDS diagnosis in the United States. The CDC identifies gay and bisexual men of all races, African Americans and Hispanics/Latinos as disproportionately affected by the disease. Broken up by gender, about 75% of all HIV cases are male with the remainder being female (Prevention October 2008). Without a doubt, gay and bisexual men make up most of the infections estimated to be among men.

There are four modes of transmission. However, there are seven categories to estimate prevalence by transmission. Forty-eight percent of all infections are attributed to men who have sex with men, or MSM. This is by far the largest category of infected persons. Twelve percent of all infections are among male injection drug users (or IDU). Seven percent are among female IDU. Five percent are MSM who are also IDU. Nine percent of infections belong to high-risk heterosexual males. Eighteen percent belong to

high risk heterosexual females (Prevention October 2008). These are females who are not IDU but are infected through sexual contact with a male. Note that this is the second largest category of prevalence.

CDC also provides estimates of prevalence by race. Forty-six percent of all infections belong to African Americans. Thirty-five percent are among white persons. Eighteen percent among Hispanic/Latino persons and 1% and slightly less than 1% belong to Asian/Pacific Islanders and American Indian/Alaskan Native, respectively. Considering that Blacks and Hispanic and Latinos make up 12% and 15%of the population, respectively, yet comprise 63% of the total infections, it is safe to say that persons of color are disproportionately affected by HIV (Prevention Hiv and aids in the united states: A picture of today's epidemic 2008).

My research aligns risk factors for HIV with Social Dominance Theory in an attempt to illuminate new policy responses to structural risk factors. Since part of my research concerns male sexual dominance of female sex partners, a review of epidemiology among women living with HIV seems relevant. These figures are again from CDC.

In real numbers, there about 278,400 women living with HIV in the United States. About 73% of these infections can be attributed to high risk heterosexual contact. CDC further refines these numbers and identifies 11% of women are infected via sexual contact with an IDU male and 62% are infected via sexual contact with a male who has another risk factor. Twenty-four percent of women are infected through sharing needles during

IDU and about 2% of women living with HIV have an "other/not identified" risk factor (Prevention Hiv/aids surveillance in women 2008).

Black women make up the highest percentage of new diagnoses made in 2006, the latest year for which CDC has made data available (these data are taken from 33 states that have had name based reporting since 2003; it excludes states like California, Georgia, Pennsylvania and Massachusetts, among others).There were 35,180 new infections, 9,252 among women, in 2006. Black women comprise 65% of new infections. White women make up 18% of new infections and Hispanic women make up 15% of new infections (these numbers take into account all risk factors). However, considering that Black women make up only 13% of the population, it is safe to say that they are disproportionately affected by HIV. Hispanic women make up 11% of the population and White women make up 71% percent of the population (Prevention Hiv/aids surveillance in women 2008).

HIV/AIDS policy in the United States

Policies relating to HIV in the United States can be broadly categorized as either treatment or prevention policy. Domestic AIDS policy differs from what is called for under the terms of PEPFAR. This has made the United States government the subject of much criticism. It should be noted, however, that policy has always been the subject of scrutiny and criticism. The Reagan administration's refusal to even acknowledge the existence of HIV, let alone establish a federal response, has largely been credited for the

extent of the pandemic on American soil. Critics of modern policy cite comprehensiveness as the chief deficiency.

Several programs have been established, or modified, to ensure access to care for people living with HIV. These programs include Medicare, Medicaid and Supplemental Security Income—all of which provide funds for care. Substance Abuse and Mental Health Administration programs provide drug treatment facilities and programs. HOPWA (Housing for People with AIDS) provides funds to establish and maintain housing (Stein 1998). ADAPs (AIDS Drug Assistance Programs), which are run by each state, provide medications for HIV and related conditions (Institute 2006).

Recent changes in Medicare eligibility mean that people living with HIV must now pay out of pocket before coverage begins. SAMHSA and HOPWA programs are plagued by budgetary constraints. HOPWA programs must also exclude those with active addiction. ADAP eligibility, coverage and waiting lists vary dramatically from state to state. Some cover as little as three HIV drugs. The funding structures for HIV treatment programs have also been the subject of controversy. Programs funded through appropriation are shrinking while programs that are funded in conjunction with enrollment are expanding (Institute 2006).

Prevention policy addresses education and testing. The United States government has supported abstinence only education in schools. Approximately $1 billion has been spent on this type of education. Condoms are not readily available in secondary schools (Institute 2006).

The role of prisons in the HIV pandemic has been well established. Some are infected in prison through sexual contact and needle sharing despite institutional policies that prohibit this kind of behavior. When released inmates return to their home communities they either bring disease with them or their care becomes the responsibility of the community. Condoms, bleach kits and needle exchange programs are not available in prison (Institute 2006).

The development of rapid HIV antibody testing (results are delivered in 20-40 minutes depending on the type of test used) has made diagnosing HIV easy and quick. In 2006, CDC provided funds to increase the availability of rapid HIV tests. In addition to itsfocus on testing, the CDC promotes perinatal prevention and secondary prevention programs (Institute 2006).

PEPFAR stipulates that foreign countries receiving aid should establish one national decision making authority with respect to HIV policy, one national AIDS plan and one system for monitoring progress and evaluation. One chief criticism on American policy is that these stipulations have not been considered when making policy. Indeed, Centers for Disease Control and Prevention, Health Resource and Services Administration and Office of National AIDS Policy all have authority when it comes to setting AIDS policy (Institute 2006). The government has taken steps towards establishing a unified monitoring system, but the literature suggests it will take several years before data become available.

Biological explanations for epidemiological discrepancy

Felissa Cohen in a chapter for the book *HIV Infection and AIDS in Women* cites several reasons for high rates of infection among heterosexual women. Cohen says that male-to-female transmission during sex is efficient. The vagina retains deposits of semen for several days and is lined with cells that permit HIV infection. Furthermore, semen contains a greater amount of virus than vaginal fluid. Cohen also tells us that 1% of infections are among the women who have sex with women, or WSW (Cohen and Durham 1993). However, most of these infections are attributed to the infecting partner being an IDU.

There are several other biological factors that make transmission from male to female very efficient. A younger age of sexual debut or first pregnancy is correlated with likelihood of HIV infection according to "The Epidemiology of HIV and AIDS in Women." Further, the presence of an untreated sexually transmitted disease, which can be very difficult to diagnose for a woman, actually facilitates the acquisition of HIV infection (Kurth 1993). This fact has been examined in the medical literature many times and is discussed at length in "Epidemiology and Natural History" by Kathryn and Sten Vermund which appeared in *Until the Cure: Caring for Women with HIV* edited by Ann Kurth.

Social explanations for epidemiological discrepancy

Because of the nature of the way HIV is transmitted, social science has had an interest in understanding the behaviors that lead to high risk sex. *The Gender Politics of HIV/AIDS in Women: Perspectives on the Pandemic in the United States,* by Nancy

Goldstein and Jennifer Manlowe, attributes high rates in infection in women to relationship dynamics, gender role expectations, self-esteem issues and self-efficacy among women, the impact of violence and attitudes toward sex and condom use (Goldstein and Manlowe 1997). The authors write that women have difficulty asserting themselves and behaviors are often motivated by concern for others. Goldstein and Manlowe also examine gender scripts as they relate to risk factors. They write that women's understanding of gender roles contributes to the formation of culturally learned scripts for what is considered normal behavior. These scripts, however normative, are what restrict a woman's attempt to control her health. The conclusion of their study, however, is that interpersonal power can be a limiting factor in choices for safe sex. The manifestations of interpersonal power can be everything from persuasive language to sexual assault (Goldstein and Manlowe 1997).

"Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women," written by Gina Wingood and Ralph DiClemente, connects risk factors for HIV to one of the three components of Connell's Theory of Gender and Power. The three structures that commonly characterize the gendered relationships between sexes include the sexual division of labor, the sexual division of power and the structure of cathexis (Wingood 2000). For example, women with a history of sexual and physical abuse have, as Wingood and DiClemente say, a physical risk factor for HIV infection. This risk factor can be categorized under the sexual division of power heading of Theory of Gender and Power. Wingood and DiClemente write, "Women's lack of power in heterosexual relationships

often translates into constraints on their sexual behavior" (Wingood 2000, 549). They go on to write that women with a history of abuse are less likely to use condoms because of the abuse, making this risk factor congruent with its category (Wingood 2000). Wingood and DiClemente ultimately assign twenty-eight risk factors for HIV to one of the three major structures of Theory of Gender and Power.

Krishnan and Dunbar, et al. examine codependent economic and gender inequities in creating risk for HIV in women in "Poverty, Gender Inequities and Women's Risk of Human Immunodeficiency Virus/AIDS." The authors illuminate four structural pathways for HIV risk factors, all of which are modifiable: lack of access to information and reproductive health services, limited access to formal education and training, intimate partner violence and the negative consequences of migration induced by the need to mitigate economic circumstances. The authors claim that structural pathways stem from underlying risk environment (which includes poverty and gender inequities) and create risky sexual behaviors. Adverse health outcomes, like HIV, which are consequences of risky sexual behaviors, in turn create an underlying risk environment and the opportunity for more structural pathways to bridge the gap to high risk behavior (Krishnan 2008). The cycle is a self-reinforcing feedback loop. The authors conclude that altering structural pathways is an effective means of primary HIV prevention for women.

Cohen also writes about social aspects of infection. She argues that women are perceived, by themselves and their male partners, to be powerless in a sexual relationship. She writes that a consequence of this powerlessness is that women are unable to advocate for preventative measures during sex (Cohen and Durham 1993).

Further compounding social aspects of infection, as cited by Cohen, are that many women do not think of themselves as at risk (Cohen and Durham 1993). Woman may be naïve to the fact that a male partner is sexually active with other partners or is an IDU who is sharing needles (Cohen and Durham 1993). Women may also simply be unaware of the sexual and risk histories of their partners. But, for women of color in high seroprevelance areas, drug use and high risk sexual behavior is simply common. The sexual encounters of many women simply carry a high probability of contact with an HIV infected individual.

INEQUALITY AND HEALTH

The theme in much of medical sociologist Richard Wilkinson's work is that inequality is unhealthy. Wilkinson writes that the death rate is two to three times higher among people in the lower social classes in developed countries with high rates of inequality. Wilkinson also notes that murder and violent crime rates are higher where there is more inequality (Wilkinson 2001). Among other elements, inequality encourages selfishness, antisocial and violent behavior (Wilkinson 2005). For Wilkinson the connection between inequality and sickness is simple: inequality affects the quality of the relationships one has and the amount of stress one experiences (Wilkinson 2005). Stress and quality social interactions are crucial determinants of health.

In *Mind The Gap: Hierarchies, Health and Evolution*, Wilkinson examines the relationship between income and mortality. Wilkinson found that social status is directly related to health-the higher one is on the social ladder, the healthier one is. Likewise, the less social status one has, the less healthy one is likely to be (Wilkinson 2001). Wilkinson believes that two of the most important social determinants of health are status and the quality of one's social relationships.

Mind the Gap: Hierarchies, Health and Evolution also explores the health impacts of dominance. Wilkinson discovered that living in unequal social structures is highly stressful. The stress of this experience has grave psychological consequences

which, in turn, affect the way human bodies function. Wilkinson writes that the societies with the longest life expectancies are the most egalitarian, most cohesive and least stressed. Moreover, Wilkinson found that societies need not be uniformly wealth—they need simply to have little variation between income levels between the richest and poorest segments (Wilkinson 2001).

Wilkinson identifies a linear pathway between income inequality and sickness in *The Impact of Inequality*. He writes that greater income inequality leads to an increased sense of social distance between members of a society. This in turn contributes to the formation of dominance structures and discrimination with leads to competition among individuals. Increased competition harms social relations and contributes to a greater incidence of sickness (Wilkinson 2005).

In *The Impact of Inequality*, Wilkinson examines the health effects of dominance. Specifically, dominance affects both social status and stress—both of which are directly related to health. Wilkinson also writes that dominance can affect our friendships and relationships with others (Wilkinson 2005). In short, dominance, like other forms of inequality, affects health outcomes.

IDENTIFYING THE ROLES OF GENDER, PLACE AND POWER IN SOCIAL DOMINANCE: EXAMINING THE LITERATURE

Overview of Social Dominance Theory

Jim Sidanius and Felicia Pratto introduced Social Dominance Theory in their book *Social Dominance* published in 1999. The purpose of the book, besides cataloguing the process by which one group maintains supremacy over another, is to align the world of individual personality and attitudes with the world of institutional behavior and social structure (Sidanius and Pratto 1999). In terms of my own work, this is important because I will link dominance and to risk factors, and subsequently, HIV. This exercise will also aid in developing a theory for evaluating equitable social policy—the antithesis of our present set of policies.

Social Dominance theory begins with what Sidanius and Pratto call Social Dominance Orientation—the belief that hierarchy is valuable and should be preserved. Social Dominance Orientation is fed by four characteristics of social groups—their status, sex or gender, socialization and temperament (Sidanius and Pratto 1999).

Social Dominance Orientation, in turn, flows into legitimizing myths that set the groundwork for the processes that drive group based hierarchy. Legitimizing myths include racism, sexism, multiculturalism or universalism (different myths support different components of a social hierarchy). Legitimizing myths provide moral and

intellectual justification for social processes that contribute to hierarchy. They consist of attitudes, values, beliefs, stereotypes and ideologies (Sidanius and Pratto 1999).

Three processes are fed by, and to some degree feed, these legitimizing myths and create a group based hierarchy. The first is aggregatcd individual discrimination. The second is aggregated institutional discrimination. The third is behavioral asymmetry (Sidanius and Pratto 1999).

Aggregated individual discrimination refers to unpretentious, common acts perpetrated by one against another that are discriminatory. They may be perceived as harmless, but when they are compounded, or aggregated, their meaning becomes much more potent. Aggregated individual discrimination helps to define power differences between social groups. An example of this kind of hierarchical sustaining process, according to Sidanius and Pratto, is a decision not to hire someone from a particular minority group or a decision not to vote for someone because of their race (Sidanius and Pratto 1999).

Aggregated institutional discrimination occurs when the combined effects of institutional policy unfairly distribute social value to one group or direct it away from another. Sidanius and Pratto state that institutional discrimination occurs in courts, hospitals and lending institutions, among others. A broad example of aggregated institutional discrimination might be a system of laws that caters to the interests of the dominant party, yet is written with the pretense of maintaining safety and order. A more accessible example of aggregated institutional discrimination might be the decision of

many health care institutions not to treat HIV infected persons in the 1980s. This decision, along with policy level decisions made by the government, helped to stigmatize HIV infected people and gay men, who made up a disproportionate number of the people living with HIV (Sidanius and Pratto 1999).

Behavioral asymmetry refers to differences in behavior among members of groups at different points of power that buttress these relationships. In essence, behavioral asymmetry helps shed light on the fact that power relations are a cooperative process—that both dominant and dominated work to maintain systems of hierarchy. Sidanius and Pratto offer four categories of behavioral asymmetry: asymmetrical in-group bias (favoring a peer—most often employed by those in dominant position), out-group favoritism (when subordinates favor dominants over their peer subordinates), self-debilitation ("when subordinates show higher levels of self-destructive behaviors than dominants do" (Sidanius and Pratto 1999, 43)) and ideological asymmetry (supporting a legitimizing myth, like sexism, to one's own detriment). The element of behavioral asymmetry most relevant to my research is that groups at different points along the continuum of power will behave in a way that reinforces the system of domination. They behave as they do because of the cues they feel from their place in the spectrum of power. In this way, behavioral asymmetry is a feedback loop. It is created by and maintains systems of power. (Sidanius and Pratto 1999)

Social Dominance Theory operates on several assumptions. The first is that this particular kind of dominance exists among social groups that have an economic surplus.

The second is that sexism, racism and other forms of oppression emerge from a predisposition to form a social hierarchy. Last, that social differentiation with the invidious aspect of social stratification is the counterpoint to hierarchy based human social systems (Sidanius and Pratto 1999).

Theory of place

I intend to use theory of place literature to show that when dominance scripts are enacted in the same place, they are given a meaning that can be interpreted as biased and unfair. Essentially, when dominance scripts are enacted in a place and nothing is done to counteract them, those places are prescribed a gendered meaning.

Roger Barker argues that settings are important determinants of behavior in *The Power of Place.* Fundamentally, people and their inanimate surroundings create ideas and systems of order which we do not like to disrupt. Our environment conditions us to maintain status quo. Furthermore, the longer we are able to practice behavior in a particular place, the more difficult it is to change. Barker writes, "A way becomes the way" (Barker 1993, 128) after behavior scttings are used long enough.

Barker also writes that our environment helps us transition from role to role. For example, as one travels from home to work, one's segue from parent to salesperson is reinforced. Predictable surroundings help us transition most comfortably and performing a role in new setting is accompanied by unease. Similarly, playing a role that is not harmonious with one's surroundings can be awkward. However, people often use their conditioning effects of place to their advantage. The environment may help one to be

aggressive (e.g., a sports field or arena) or energetic (e.g., a dance club). In a sense, people learn to associate environmental cues with what to expect in a particular place. These cues tell us how to behave and also what behavior to expect from others.

Relph, in *Place and Placelessness,* argues that places acquire meaning simply because of the activities that go on in them. He writes that there is both self-conscious and unself-conscious making of place. Self-conscious place making is an attempt to relate a clear and complete concept of the person living in that space. This kind of place making is usually done be elite social groups. Unself-conscious place making, on the other hand, has no theoretical underpinnings. It is fully in harmony with the intentions of those who create it and is a literal translation of ideas into the physical form (Relph 1976).

Gender and place

Scholars have used gender and place theory to examine inequality. Daphne Spain, in *Gendered Spaces*, writes that spatial segregation of the sexes affects the geography of knowledge. Spain studied twentieth-century office spaces and concluded that sexual segregation limited access to valued knowledge by women. As a result, their position was always subordinate to men's. A woman's limited access to knowledge in this place essentially created a system where men were perpetually in positions of power and privilege (Spain 1992).

Spain writes that social structure is not always the result of spatial patterns. Rather, these spatial patterns become institutionalized and influence future social processes (Spain 1992). The place theory in Spain's argument is clear—she is writing that

the sexual segregation created a series of cues that informed behavioral patterns of the future. The behavior of the future sought to maintain the status quo—as people have the tendency to do. Unfortunately, however, the status quo involved an inconsistency in power and knowledge among sexes.

Jos Boys considers place and gender in her chapter titled "Beyond Maps and Metaphors: Re-thinking the relationship between architecture and gender" which appeared in *New Frontiers of Space, Bodies and Gender.* Broadly, Boys challenges the assumptions we make about social values because of features in the built form. She tells us the both the suburban home and the ghetto are representative of specific social behaviors that have come to provide behavioral repertoires for their occupants. Rather, the relationship between person and place needs to be thought of in terms of identity, desire and memory (Ainley 1998). Boys is telling us to think about how we culturally define spaces.

Feminist perspectives on sex and power (gender and power)

Sexuality and sexual behavior has been a primary source of inquiry for feminism. Diane Richardson provides an overview of feminist concepts of sexuality in "Sexuality and Male Dominance" which appeared in a book she edited entitled *Thinking Feminist: Key Concepts in Women's Studies.* For some scholars, sexual acts are seen as the primary means by which men maintain social dominance over women. It has been argued that sexual relationships between men and women reflect and maintain patterns of female subordination and male dominance (Richardson and Robinson 1993). Richardson points

out that patterns of male sexual behavior, especially in the United States, involve conquering and domination. Sex is understood by men as something they *do* to women and their urges are uncontrollable. Women, on the other hand, can experience pleasure and satisfaction through surrendering to man (Richardson and Robinson 1993). Gender concepts of both sexual behavior and partner roles, especially as understood from the feminist perspective, are easily integrated with studies of social power.

INTEGRATING GENDER, POWER AND SPACE

This section of my thesis has examined concepts of gender, power and space. Some research exists that integrates two of these three concepts, but I am proposing that risk factors be considered in light of all three concepts—as illustrated in Figure 1. The next section of this thesis examines risk factors for HIV that are constructed through processes of aggregated individual discrimination, institutional discrimination and behavioral asymmetry. These processes create structural risk factors—like poverty, homelessness and commercial sex work. All of these risk factors for HIV contain elements of gender, power and space and, to be sure, many of these risk factors lie in the areas they share. In other words, living in poverty—a structural risk factor—needs to be considered an issue of power and space and not just an issue of money. Conceptually, gender, power and space can be organized as follows:

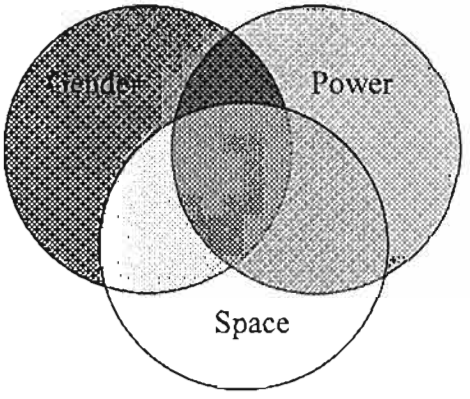

Figure 1. Risk Factor Dimension and Interdependence Model

Most risk factors lie in the areas shared spaces—meaning they have more than one dimension.

Most HIV prevention programs teach personal behavior change. While I do not dispute the importance of personal agency, I am calling for structural changes-essentially eliminating institutionalized systems that create privilege, eliminating individual expressions of power over others and creating a social context that teaches self-efficacy. Moreover, I am calling for developing policy rooted in equality, accessibility and tailored to meet the needs of individual communities.

Recapitulation of central themes

The chief goals of my research are to examine power structures that generate risk factors for HIV and to establish the role of place in the power dynamics of sexual relationships. In light of these goals, the relevant themes from the literature are that a discrepancy in the epidemiology of HIV infection exists between men and women; inequality has negative health outcomes; Social Dominance Theory provides a framework from which to examine risk factors for HIV; policy revisions—aimed at reducing risk factors for HIV—should be considered in light of the failure of policy decisions to this point.

FINDING THE STRATEGIC DOMAIN: TARGETING POLICY RESPONSES

The antithesis of our present situation is encapsulated in the Equitable Social Policy Model—whose labels are the just responses to the problematic aspects of gender, power and space and are presented in Figure 2. My theory posits that appropriate policy responses to structural risk factors will lie in the shared spaces of the second diagram. In other words, we must reject dominance and instead embrace its inverse—equity—if we have any hope of eliminating structural risk factors and structural risk factors will naturally disappear as we ground future legislation in gender, racial and socioeconomic equity. My argument is based on Wilkinson's conclusion that equality contributes to health. To summarize, my Equitable Social Policy Model, if you will, illustrates

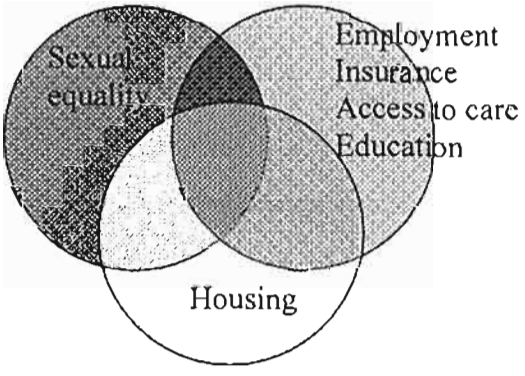

Figure 2. Equitable Social Policy Model

dimensions of policy and their interdependence needed to reduce structural risk factors—to move towards social equity.

To illustrate, one policy discussed after institutional discrimination states that calculations for entitlements should be reformulated to include food, clothing, shelter, child care, transportation, tax liabilities and medical expenses. Since this policy is aimed at increasing entitlements for women who might otherwise make income through commercial sex work, this structural change (preventing sex work by providing income from an alternative support) acknowledges the dimension of sexual equality (providing entitlements based on the unique needs of women); the dimension of housing (ensuring that recipients do not have to prioritize any basic needs—that all are met); and the dimension of employment, insurance, access to care and education (that medical expenses and child care costs are part of the entitlement calculation).

FACTORS CREATED BY AGGREGATED INDIVIDUAL DISCRIMINATION

Sidanius and Pratto identify Aggregated Individual Discrimination as the common occurrences of discrimination that an individual encounters over a long period of time. Considered individually, they may be heinous, but after a time, they illuminate power structures and help an individual formulate ideas about his/her place in the social hierarchy. In this section, I illustrate how Aggregated Individual Discrimination creates a structure from which psycho-social risk factors for HIV emerge. These risk factors are commercial sex work and sexual abuse. A section on policy responses to prevent discrimination and empower victims follows. Not surprisingly, risk factors for HIV are overlapping. As a consequence, policy responses to the structures that create risk factors are too.

Gender and power: commercial sex work as consequence of aggregated individual discrimination

Prostitution is the quintessential low control/high demand work environment for women. Among scholars, there is broad consensus that women enter prostitution as a result of experiences in childhood and adolescence (Vanwesenbeeck 1994). These experiences are all acts of individual discrimination and include sexual and physical abuse and negative sexual experiences. Still others enter prostitution because of violence

or threat of violence from a pimp. Indeed, some qualitative data provide evidence that pimps lure women into prostitution with the promise of easy money (Vanwesenbeeck 1994). Still violence and money are both used as coercive tools and, when they are used enough, meet the criterion for aggregated individual discrimination.

In addition, contracts between sex workers and their clients have been characterized as inherently unfair (and discriminatory at the individual level). While some offer the service and payee model, the reality of most transactional sex acts is much more severe. Sex workers are viewed as employees by paying clients and, as such, are paid to obey (Jeffreys 1997). This limits the options for sex workers in terms of safer sex practices, the option to leave and to object to a behavior without fear of retaliation. Sex workers are not treated well and develop an understanding of their role over time as near the bottom of the social hierarchy.

Gender and power: physical and sexual abuse as aggregated individual discrimination

Abuse is viewed as expressing power over another. This may include redirecting anger towards a child and perceiving women and children as objects or even as equals. Often, abusers abuse because of a fascination with sexuality and sexual prowess. Portrayals in the media acts aggregate in the mind and normalize abusive behavior (Mayer 1985). Regardless, aggregated individual discrimination is repeated acts of expressing power over another and physical and sexual abuse is an important component of any study that examines systems of power and risk factors for HIV.

Policy considerations and responses that reduce aggregated individual discrimination

Aggregated individual discrimination occurs on a person to person level (which is not to say that perpetrators discriminate towards more than one person or victims do not experience discrimination from more than one person). As a result, policies that address power and gender inequities must do so on an individual level—meaning they must empower the disenfranchised and rein in those with a sense of privilege. The policies discussed below, a fraction of what could be considered appropriate, help to end gender and racial based privilege, promote tolerance and nonviolent conflict resolution.

A women's center and shelter in Duluth, Minnesota partnered with a school district to develop a program entitled "Hands are Not for Hurting" for inclusion in the school curriculum. The program teaches tolerance, nonviolent conflict resolution and accountability and seeks to have a lasting impact on domestic violence (Leon-Guerrero 2005). By focusing on nonviolent conflict resolution and tolerance to end abuse, ideas of gender and power equality are introduced to participants. These ideas provide a counterbalance to ideas of inequality.

The Violence Against Women Act passed in 1994 permitted women to sue their attackers in federal court for damages (Stetson 1997). This extension of federal rights is seen as pivotal in recasting rape as a crime of violence perpetrated by one individual against another (legal definitions of rape previously defined rape as crimes of morality and defined women as property of men). Legislation that extended the same federal civil

right to victims of sexual abuse, even children, would serve as a deterrent and change societal tolerance of the crime. This policy would help to correct the imbalance of power that exists among victims and abusers and brings the punishment in-line with the nature of the crime.

Researchers have proposed that legalized prostitution—a compromise between an outright ban and unregulated decriminalization—would protect the public and the health of sex workers and clients. A commission would be created to monitor the industry. Additionally, it has been proposed that a branch of this regulatory office be created to assist women looking to exit commercial sex work. Prevention case management for women seeking to enter sex work might reduce the number of active sex workers (Kuo 2002). This type of legislation would help to undo the "employer-employee" dynamic of transactional sex.

FACTORS RELATED TO INSTITUTIONAL DISCRIMINATION

Sidanius and Pratto identify Institutional Discrimination and rules, procedures—even policy decisions—of social institutions that favor one group or are harmful to another group. In this section, I will illustrate how Institutional Discrimination creates an economic framework from which a variety of socio-economic risk factors for HIV emerge. These risk factors include poverty, homelessness, mistrust of the medical system, lack of health insurance and lack of access to HIV related services. Policy options to promote economic equality are discussed below.

Power and space: living in poverty as consequence of institutional discrimination

Increases in both severity of poverty and the number of people living in poverty are attributable to corporate policy decisions. Some decisions can be construed as reasonable responses to market demands. However, the human consequence cannot be ignored. Overseas investment by American corporations left many domestic workers unemployed or underemployed (Timmer, Eitzen, and Talley 1994). Instituting automated processes, which replaced workers with machines, resulted in layoffs and job cuts. Employers also sought to cut labor costs by moving to temporary, "on-call" or contingent employment (Timmer, Eitzen, and Talley 1994). While some remained employed, their cut in hours or pay may have been reduced to an unsustainable level.

Chronic and intergenerational poverty is maintained by institutional discrimination. Impoverished areas are documented to have substandard schools for their children which limits employment options when employment age is reached (Perlman 1976; Schiller 2001). While employers may engage in conscious discrimination of certain groups, others have established hiring procedures that exclude people of color, people with low educational attainment and people from certain areas (Schiller 2001). These policies prevent economically disadvantaged, including women, from finding employment.

Power and space: homelessness as consequence of institutional discrimination

The causes of homelessness are numerous and complex. However, homelessness in recent decades was aggravated by policy decisions made by the federal government. The Reagan administration reduced federal support for affordable housing from $32.3 billion in 1981 to $6 billion in 1989 (Timmer, Eitzen, and Talley 1994). This resulted in massive cuts for housing maintenance and construction. At the same time, changes in the federal tax code increasing interest rates and new financing strategies removed incentives for private developers to construct affordable housing. These policy decisions resulted in a diminished supply of affordable housing and increasing rent prices for the units that remained (Baumohl and National Coalition for the Homeless (U.S.) 1996).

Simultaneously, urban renewal programs demolished affordable housing stock and replaced them with sports arenas, hospitals and airports, effectively reducing supply

even more (Timmer, Eitzen, and Talley 1994). When remaining housing in these neighborhoods became desirable (a process known as gentrification), many lower income people were displaced (Baumohl and National Coalition for the Homeless (U.S.) 1996). The poor who were housed were maintained by HUD contracts (Timmer, Eitzen, and Talley 1994).

HUD was supposed to counteract these market forces by offering subsidies to landlords who claimed they were not charging what the market would allow for their units. However, budgetary constraints forced HUD to fund existing contracts and not create new ones (Timmer, Eitzen, and Talley 1994).

This toxic combination of conditions—diminished supply, increased cost of existing units, increasing population and reduced federal support—forced many to live in homeless or inappropriately housed conditions. Lifestyle factors associated with being homeless, like drug use, victimization, prostitution, and no access to health care, create opportunities for HIV.

Power: lack of health insurance as consequence of institutional discrimination

In America, health insurance is obtained by several methods: from an employer as part of a compensation package, from the government as part of public assistance and from the government as part of assistance to older individuals (McLaughlin 2004). Lack of health insurance has been associated with HIV for several reasons. They include lack

of information about HIV transmission and testing; lack of provider knowledge about high risk behaviors, lack of access to risk reduction practices. The causes of lack of health insurance are typically the result of policy changes that disqualify some people from programs or health insurance is simply not offered by employers in an effort to cut costs. Specifically, federal programs have excluded some people on the brink of poverty. Employers claim that competition for workers does not require them to offer health insurance or that a young, healthy workforce would rather accept a higher wage than a health insurance program. Moreover, some argue that federal minimum wage requirements are a policy that prohibits some employers from offering health insurance (McLaughlin 2004). These employers could not reduce wages enough to cover the cost of health insurance while still paying a wage that is above minimum wage standards.

Power and gender: commercial sex work as consequence of institutional discrimination

Many accounts given by commercial sex workers state that they chose sex work because it was either the only way to make money or it offered the most money. Employer decisions not to hire women or people of color have forced some into sex work (Vanwesenbeeck 1994). Market forces that steer women into low paying jobs can also be driven by hiring policy (Schiller 2001).

Power: mistrust of medical system as consequence of institutional discrimination

The Tuskegee Syphilis Study is cited as the root of Black mistrust in the American medical system (Reverby 2000). Between 1932 and 1972, 399 Black sharecroppers were enrolled in a study conducted by the U.S. Public Health Service. They did not give consent, nor were they informed of the true nature of the study. Even after penicillin was available, the study continued to see which was worse, the effect of the drug or the consequences of disease (Reverby 2000).

Other scholars have argued that medical experimentation by the medical community during the Antebellum period in American history contributes to mistrust in the medical system (Reverby 2000). The accounts of the dissections and surgeries, some performed without anesthesia, are horrific. Nevertheless, it is clear that Blacks' mistrust is based on very real events and collective memory.

I am arguing that the Tuskegee Syphilis Study and experiments carried out during the Antebellum are examples of institutional discrimination toward Blacks. The policies of the medical community at the time targeted Blacks for medical research. Other policies dictated that they were not to be informed of the nature of the procedures nor did they have the opportunity to opt out. The literature has claimed that a direct consequence of these events is mistrust of the medical system by Blacks (Reverby 2000). Hence, institutional discrimination played a role in creating a risk factor for HIV.

Literature that appeared in the popular press in the 1980s exacerbated mistrust among Blacks. A 1989 Los Angeles Sentinel article claimed that Blacks were

intentionally infected. An *Essence* article entitled "Is It Genocide?" claimed that Blacks were infected to limit the size of the population. Studies have also shown that Blacks are suspicious of condoms (which are, after all, devices intended to prevent pregnancy), claiming that they are part of the genocide plan (Reverby 2000). The collective legacies of Tuskegee, the Antebellum period and early stories about HIV have complicated treatment and prevention in communities of color.

Policy considerations and responses that reduce institutional discrimination

Creating a framework to evaluate policy responses to reduce institutional discrimination should be especially powerful because nothing is lost in translation from structure to individual action—policy governs the structure. The following model policies bring equality to institutionalized and bureaucratized systems. Broadly, these policies eliminate power differentials and neutralize any privilege. To be more specific, they acknowledge the unique needs of women in housing, health care and social services; they identify and remove barriers to access; and they prevent passing harmful legislation. These model policies promote equality with respect to gender, space and power.

The first policy option to be considered is one that seeks to end institutional discrimination. A policy of this nature would ban future legislation that is detrimental to the income and housing options of the lowest wage earners (Hofrichter 2003). This policy might also ban cuts to health insurance options for this group. Legislation of this nature is a crucial first step to promoting economic equality. It sends a message that policymakers

value and care about the well-being of the lowest wage earners.

As was previously discussed, HUD's actions have driven up the price of affordable housing by reducing the number of units available in certain areas. A policy change exists that would prevent this from happening again: require that HUD rebuild at least the same number of housing units that it demolishes (Leon-Guerrero 2005).

The Urban Management Programme has suggested that affordable housing be zoned mixed-use (Vanderschueren, Wegelin, and Wekwete 1996). This would permit residents to work and live in close proximity. This may provide several advantages: it would reduce the need for reliance on transportation to get to and from work and might be a stabilizing factor for some individuals who have difficulty maintaining employment.

Still other homeless prevention policies could be administered at the local level. They include managing public housing projects efficiently and equitably, providing emergency rent assistance and increasing the number of low-income housing subsidies (Leon-Guerrero 2005). Jurisdictions might also consider simplifying the application process for these programs to increase utilization particularly among women (Leon-Guerrero 2005).

Housing policies should be considered tools to alleviate homelessness encourage equality. The obvious policy options are to increase funding quantity and affordability of housing for low wage earners (Hofrichter 2003). However, a secondary consideration for housing is to ensure that infrastructure to affordable housing is maintained by a jurisdiction. These infrastructure concerns include roads, water and sewer lines and utility connections. This policy protects the value of housing from eroding due to poor municipal

services (Hofrichter 2003).

Since some women enter commercial sex work to support families, it has been proposed that redefining the poverty threshold will eliminate the market forces that drive women to commercial sex work. The calculations for entitlements could be expanded to include food, clothing, shelter, child care, transportation, tax liabilities and medical expenses (Leon-Guerrero 2005). In addition, it has been proposed that entitlement formulas be customized to regions. Present formulas assume the same costs of living across the contiguous 48 states (Hofrichter 2003).

Nontraditional employment strategies for women that both mitigate poverty and increase equality have been proposed. These strategies generally support community based initiatives and capitalize on the unique skills of the workforce. Some offer apprenticeship programs for women entering the workforce. The programs that fund these initiatives also support outreach and workshops to attract participants and grow the program (Leon-Guerrero 2005).

Canada has instituted a variety of policies designed to alleviate and prevent poverty. They include making the minimum wage equal to a reasonable living wage; improving pay equity with respect to worker gender and ethnicity and having a guaranteed minimum income for all working-age citizens (Hofrichter 2003).

FACTORS RELATED TO BEHAVIORAL ASYMMETRY

Behavioral asymmetry is a puzzling concept. It refers to the actions taken by subordinates to create and maintain hierarchical relationships. Unlike in the previous section, the relationship between risk factors and behavioral asymmetry is more intertwine—in many instances risk factors themselves are examples of behavioral asymmetry—and risk factors reinforce power inequities in the sexual relationship. My interpretation of the relationship between behavioral asymmetry and risk factors relies heavily on feminist interpretations of sex and power. Because behavioral asymmetry is an inherently psychological concept that influences action on the part of the subordinate, I claim that behavioral asymmetry informs behavioral risk factors that can be mitigated by educational, health and social policies. Additionally, a significant knowledge gap exists and considerations for a future research initiative are identified below.

Gender and power: having a partner who disapproves of safer sex practices as behavioral asymmetry

One study found that women whose partners disapprove of condoms were 3.5 times more likely to never use condoms (Wingood and DiClemente 1998). Since feminist research tells us that male perceptions of conquest are enhanced when condoms are not used, women who do not advocate for condom use because of a partner's wishes are

buttressing the power differential in the relationship. Hence, having a partner who disapproves of safer sex practices is behavioral asymmetry—a risk factor that essentially is self-reinforcing because condom negotiation is more difficult the more time elapses in a relationship.

To be fair, a female initiated method of HIV prevention (which could undo this particular risk factor) in the form of the female condom does exist. However, they have yet to see widespread use. Their limitations include cost, availability and difficulty of use. Research has clamored for an alternative method of female initiated HIV prevention for some time.

Gender and power: having a high-risk main partner as behavioral asymmetry

Women with high risk main partners—defined as partners who inject drugs or have sex with men or women outside of the relationship—have an increased risk for HIV because the partner is at increased risk. Women in relationships like this who tolerate a partner's behavior are reinforcing the power differential in the relationship. This inaction—behavioral asymmetry—reinforces unequal sex roles and expectations; it reinforces male privilege and the idea that male female partners have different expectations for how to behave in a relationship.

Gender and power: having a desire to conceive as behavioral asymmetry

Women who want to conceive are 8.5 times less likely to use condoms (Wingood and DiClemente 1998), which generates an obvious increase in risk for HIV. Feminist scholars tell us that condoms are one way in which men assert power over female sexual partners and perceive reduced condom use in a relationship as enhanced sexual conquest. I argue that a desire to conceive is behavioral asymmetry because women are enhancing the perception of conquest on the part of their male partners by ignoring the issues of condoms and safe conception. Indeed, this behavior highlights the needs of women who wish to become pregnant and whose partners are living with HIV.

Women who use condoms less because of a desire to conceive are reinforcing the power imbalance in the relationship because male partner's perception of conquest is enhanced by the lack of condom use. Feminist thought places the condom at the nexus of male power.

Space, power and gender: desire to maintain housing as behavioral asymmetry

A portion of the women in Gentry's ethnography of urban, substance abusing women were consistently housed. All of the women admitted that the income of their male partners paid for the housing. Similarly, all of the women expressed pride in the fact that they could act in a way that maintained the relationship with the partner. The

actions included submitting to forced sex, tolerating abuse, tolerating partners' cheating, tolerating partners' drug use and having sex without a condom because it increased pleasure for the male partner (Gentry 2007). These actions all fit the definition of behavioral asymmetry while simultaneously acting as risk factors for HIV infection. While housing is frequently lauded as having benefits for those at risk or living with HIV, place frequently acts as agent for power. In other words, control of place often means control of bodies within that space.

Policy considerations and responses that reduce behavioral asymmetry

Enacting policy to decrease behavioral asymmetry is difficult—primarily because behavioral asymmetry describes a set of personal behaviors. Enacting policy might mean altering the context in which individual behavior occurs or developing programs that help to increase sense of empowerment, sense of equality and self-efficacy among oppressed individuals.

The following program and policy examples, which represent a small sample of possibilities, help to reduce behavioral asymmetry by teaching about equality, empowerment and conflict resolution. These examples have dimensions of gender, space and power to them—which is crucial because risk factors for HIV related to behavioral asymmetry have dimensions of gender, space and power as well.

A variety of existing policy options could be strengthened in an effort to help women advocate for their sexual health. Under federal abstinence only guidelines school based reproductive health services for women were established. These programs offered

sex education, counseling and reproductive health care. Long term analysis of these programs has revealed a number of positive health outcomes among those that utilize such services: decreased sexual activity, increased condom use and delayed sexual debut. Policy options to strengthen these programs include increasing services, removing the abstinence only stipulation and couples counseling and education (Leon-Guerrero 2005). Counseling and education would be especially useful if it provided components that exposed the role of space in creating power differentials in relationships and strategies for individuals in living situations where space acts as a broker for power. Research programs could provide insight into culturally competent methods for discussing power, gender and space and appropriate educational outcomes.

A complementary approach to promoting equity in relationships is to reach out to the male partner through education. Project Brotherhood, located in Chicago, Illinois opened a number of health clinics near neighborhood barbershops. The project determined that barbershops were an excellent way to reach a large number of residents—barbershops serve as a gathering place where a variety of information is exchanged. Project Brotherhood offers HIV education, in addition to information about many other health and life issues (Leon-Guerrero 2005). I propose the additional of an educational component that discusses sexual equality—like partner expectations, communication and negotiation strategies and division of household responsibilities. The educational component should discuss the fact that one does not control the bodies in a space simply because he or she has a high degree of control in that space as a relevant topic in the larger realm of sexual equality.

Finally, it would be prudent to ensure the long-term survival of empowerment programs. An almost constant concern for health and human service agencies is the threat of budget cuts. Canada has worked to minimize funding cuts by requiring that the government spend at least as much on health and human service programs as other Organisation for Cooperation and Economic Development Nations-of which the United States is a member (Hofrichter 2003).

The Urban Management Programme has suggested that primary education and health services be integrated to provide ease of access to both programs. Policies of this sort would surely increase the utilization of each program. They have also suggested that resident support of school administration is critical (Vanderschueren, Wegelin, and Wekwete 1996). Resident involvement in schools would ensure that the community has a stake in what is taught in schools. This element is especially critical given the sensitive nature of sex education, condoms and HIV. Resident involvement would make certain that community values are reflected in the curriculum.

Recommendations for research and knowledge gaps

Sometimes, services exist in an area but are not accessed by those that need them. Research that sought to understand why people do not access services is an important component of maximizing efforts already under way (Leon-Guerrero 2005). The barriers that are identified by research can then be removed to ensure access by all.

According to Sidanius and Pratto, behavioral asymmetry has a significant psychological component to it. Though research has been done to understand why people

act in ways to maintain hierarchy, there are still knowledge gaps. This work could broadly be categorized as understanding the feedback loops and system dynamics of social conditions and health.

Census data have revealed that the nuclear family is declining in America. At the same time, other family units, like single-parent, adoptive, foster, blended, same-sex and grandparents as care-takers are on the rise. Little research has been done to identify the effect of these emerging family units on youth behavior (Leon-Guerrero 2005).

Additionally, options for women with an HIV positive partner who want to get pregnant are very limited. A technique known as sperm washing is available for those who can afford it. However, sperm washing is not covered by ADAP programs or public entitlements and, thus, is utilized primarily by those who can pay out-of-pocket. Other options for women who wish to conceive are needed.

IMPLICATIONS

Social Dominance Theory provides an understanding of the way power relations are created and maintained among groups. The fact that risk factors associated with HIV infection are easily categorized within Social Dominance Theory means that risk factors are created and exacerbated by power relations among people. The obvious implication is that undoing risk factors involves correcting imbalances of power and has the potential to reduce HIV infections by removing risk factors. The exercise of linking components Social Dominance Theory with risk factors for HIV provides a template to evaluate social policies that promote equity.

Discrimination has adverse health outcomes

Wilkinson tells us that dominance is stressful and harmful to social interactions. Because stress and interactions are important markers of health, high stress and poor social interactions lead to increased disease incidence. While I do not dispute Wilkinson's claim, I am arguing that dominance, specifically intergroup dominance (that which seeks to preserve existing social stratification), creates a framework from which a variety of socio-economic, personal and behavioral risk factors for HIV emerge. In this way, the actions taken by a privileged group of decision-makers have health consequences for the socially subordinate.

I argue that social processes identified by Sidanius and Pratto—aggregated individual discrimination, institutional discrimination and behavioral asymmetry—are the genesis of risk factors for HIV that have a social component. Because of this, altering the framework from which risk factors emerge should have an effect on rates of HIV infection.

Social policy may have an impact on rates of HIV infection

United States HIV/AIDS polices have had varying degrees of success. I am proposing policies aimed at reducing or preventing risk factors. Targeted policies that seek to decrease homelessness, increase employment opportunities, reduce violence, etc. should be considered secondary means of prevention for HIV. Broad polices that increase equality among sexes and socioeconomic groups—policies, in other words, that elevate the status of some without doing harm to others—should also be considered secondary prevention measures. Policies of this nature should be considered complementary to legislation specifically targeted at reducing the incidence of HIV.

Place and control of place should be considered in risk factors for HIV infection

With regard to people living with HIV and those at risk for HIV, housing is widely regarded as a protective factor. Research has shown that housing creates stability in one's life and results in fewer hospital visits. Stable housing is also an important factor in predicting medication adherence and seems. Housing is important component for safe

injection among drug users. However, I am arguing that place is an agent for power. In other words, cohabitation with a male partner who controls the living space can introduce risk factors for the female partner. Studies show that women who rely on men for housing often ignore their partners' sexual relationships with others and their drug using behaviors are ignored—chalking their behavior up to male rights and privilege. Moreover, women regard their male partners as steady, so condom use is likely diminished or nonexistent.

The conspiratorial nature of risk factors and aggregated individual discrimination, institutional discrimination and behavioral asymmetry

Although aggregated individual discrimination, institutional discrimination and behavioral asymmetry do not produce the same kinds of risk factors, the frameworks they establish are diabolically compatible. For example, commercial sex workers are sometimes homeless, lack health insurance and lack trust in the medical community. Poverty often accompanies unemployment and action taken to maintain housing. Because of this, I argue that frameworks and risk factors are synergistic—and the proof is that most people living with HIV have multiple risk factors.

Unfortunately, this idea also has policy implications. It means that efforts to undo one risk factor must be simultaneous with efforts directed at other risk factors. Solitary acts of legislation aimed at eliminating poverty are likely to do little unless homelessness and lack of insurance are also addressed.

DIRECTIONS FOR A RESEARCH INITIATIVE

This paper has aligned structural risk factors for HIV with concepts of dominance illuminated by Sidanius and Pratto—partly to suggest that the severity of the HIV pandemic can be attributed to social inequality—but also to clarify the interdependence of risk factors. I have suggested that just as risk factors are related, so too must our policy responses and that future legislation must be grounded in equality to impact rates of infection. A variety of research questions arise from thinking about risk factors and policy implications in this way.

Chiefly, what will happen to the rate of new infections if policy actions reduce structural risk factors? If we work to reduce the number of homeless, increase accessibility to health care and health insurance, would that have any effect on domestic rates of HIV?

Further, we need to develop an understanding of the way risk factors work together to promote HIV. Ethnographies and case-studies should be employed and modeling programs may help us understand the self-reinforcing nature of multiple risk factors. This research is a critical first step in developing specific policy responses.

Speaking of policy responses, we must develop an understanding of the ways that policies work together. Legislation related to housing subsidies, health insurance and employment programs could all potentially affect women at risk for HIV—but what is the effect of all three policies on women at risk for HIV?

We must also develop a method of educating our legislators about how policies work together. Acts of legislation do not work in a vacuum. Rather they interact with all the other policies that exist.

Legislators must also be aware of how fundamental equality is in drafting policy. In order to prevent policy from doing harm, the value of equality must be embraced and it must serve as a foundation upon which all policy statements are crafted.

Research should also be conducted to ascertain whether or not removing structural risk factors is more or less expensive than treating HIV infections. The literature tells us that HIV is a very expensive disease to treat and that treating HIV is less expensive than treating the opportunistic infections that appear in the AIDS stage. I propose weighing the costs associated with providing housing, health insurance, a sustainable wage against the costs of treating someone with antiretroviral medications for several decades.

Finally, research related to social capital has not yet been integrated in to HIV prevention programs. Many of the policy solutions I have proposed in this paper—especially those related to power—seek to redress gender and racial inequalities by increasing the social capital of the subordinate group. HIV prevention programs and strategically enacted policies could benefit from social capital theories but only if we have a firm understanding of interrelatedness of risk factors and inequality.

CONCLUSION

This paper has examined the interdependence of dominance, theory of place and gender in the creation of risk factors for HIV. I offer policy options in an attempt to increase equality among genders and socioeconomic groups. Several policy changes seem to be key relative to HIV: increasing access to housing and healthcare, increasing entitlements and ensuring that existing programs are adequately funded and accessible.

It would be naïve to think that we could legislate our way to a reduced rate of infection in the United States. Individual behavior change, the role of condoms, clean needles, testing, prevention case management and education are significant components of a comprehensive domestic policy. There is, however, value in looking at the role of policy in removing structural risk factors as part of a systems approach to reducing HIV prevalence in the United States.

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