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Mark S. Kaplan

University of Illinois, Urbana-Champaign

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Feminization of the AIDS Epidemic

MARK S. KAPLAN

University of Illinois at Urbana-Champaign
School of Social Work

Although males still constitute a substantial number of persons with AIDS, it is becoming clear that this is a disease affecting women and minority populations more adversely. Today women, while representing approximately 16 percent of all AIDS cases nationwide that are reported to the Centers for Disease Control, make up the fastest-growing segment of the population with AIDS. This article contends that AIDS is increasingly afflicting women who have little economic, political, or social power. Furthermore, misdirected public policy has been partly responsible for the greater incidence of the disease in certain regions and populations.

“It’s just another plague visited on people who are plagued by other plagues”

—New York City AIDS worker
(Gould, *The Slow Plague*, p. 134)

In a controversial report released in 1993 on the social impact of the epidemic of AIDS (acquired immune deficiency syndrome) and HIV (human immunodeficiency virus) in the United States, the National Research Council (NRC) (1993, p. 9) concluded that “AIDS is an undemocratic affliction.” Equally ominous, the NRC noted, is the “failure by scientists and policy makers to appreciate the interaction between social, economic, and cultural conditions and the propagation of HIV/AIDS disease has often led to public misunderstanding and policy mistakes about the epidemic.” For example, although there is growing concern about the use of injection drugs as a social behavior that transmits infection, policymakers have often ignored the place of such behavior in a matrix of social, cultural, and economic conditions.

In this article, I argue, along the lines suggested by the NRC, that HIV/AIDS is increasingly afflicting individuals with little economic, political, or social power. Furthermore, I contend that misdirected public policy has been partly responsible for the greater incidence of HIV/AIDS in certain regions and populations in the United States.

In June 1981, the Centers for Disease Control (CDC) discovered patterns of health problems among gay, white men, all of which involved compromised immune systems. It was later revealed that cases of these health problems, which were not then identified as AIDS, had appeared in the United States in the late 1970s and in sub-Saharan Africa as far back as 1959 (Perrow & Guillen, 1990). The affliction was initially considered as a "gay disease," a disease of male homosexuals, and the term GRID, for "gay-related immune deficiency," was proposed in 1982. Thus, although injection drug users who were not gay men were identified as having the disease as early as July 1981, just one month into the epidemic (Perrow & Guillen, 1990; Wells & Jackson, 1992), AIDS has been associated primarily with gay men since it was first recognized by the CDC.

Unfortunately, images of the epidemic in the press and the popular mind still equate HIV/AIDS with men, especially gay men. In spite of significant demographic changes, the media coverage of the AIDS epidemic among women has been relatively scant (Devitt, 1993; Overall, 1991). In the mass media, what little is reported usually serves to deepen common prejudices, rather than functioning to raise public awareness, by treating women as vectors of transmission to infants and men, rather than as victims (Devitt, 1993). For example, as part of a week-long series on AIDS in Asian countries broadcast over National Public Radio (February 22, 1994), a reporter in describing heterosexual transmission in India made the following statement: "infection begins with the prostitute." In her analysis of print media coverage of the HIV epidemic among women, Devitt (1993, pp. 10–11) wrote that

the majority of articles in the U.S. press on women with AIDS allude to the prevalence of HIV among prostitutes. But in almost every instance the emphasis is on the potential for sex workers to

spread the disease, rather than catch it. . . . If news accounts dealing with HIV-infected women did not discuss prostitution, they usually focused on the plight of HIV-positive women's children, emphasizing the transmission of the virus from mothers to fetus.

Although men still constitute the majority (84%) of persons with AIDS nationwide, it is becoming increasingly clear that AIDS is affecting women and minority populations more adversely than it does others (National Research Council, 1993; National Commission on AIDS, 1992). Women are more likely to acquire HIV directly through injecting drugs (50 percent) and indirectly through sexual exposure to partners who inject drugs (20 percent) (CDC, 1993a).

Changing Demography and Geography of AIDS

Since 1987, there has been an demographic shift in the epidemic, with a greater representation of women and minority populations, groups who are already marginalized socially, politically, and economically from the mainstream of society. Today women, while representing approximately 16 percent of all adult and adolescent AIDS cases nationwide that are reported to the CDC (CDC, 1994), are the fastest-growing segment of the population with AIDS. Moreover, African American women and Latinas have cumulative incidence rates of AIDS that are, respectively, 15 and 6 times that of white women (CDC, 1994). Seventy-nine percent of these cases have occurred among women in their reproductive years (CDC, 1993). Between 1987 and 1991, the number of AIDS cases among women in the United States increased by more than 1000 percent (Ickovics & Rodin, 1992). And in 1992, according to the CDC (1992b), diagnosed AIDS cases increased 30 percent among women, compared to 22 percent among men. Although African American women and Latinas account for about 21 percent of the total female population of the United States, they make up about 75 percent of all cases of AIDS among women nationwide (CDC, 1994).

AIDS mortality data demonstrate growing class-, race- and gender-based disparities. In 1992, AIDS was the fourth leading cause of death for women in the 25-44 age group (up from

the fifth in 1991) (19.9 and 7.3 percent of the deaths, respectively) (CDC, 1993b). From 1991 through 1992, a larger proportionate increase in reported deaths from AIDS occurred among women (9.8%) than among men (2.5%). The rates were higher for African American women and Latinas (13.3 and 14.6 per 100,000, respectively) than for white women. AIDS also became the second (up from third in 1991) leading cause of death among African American women aged 25–44 in 1992 (12.1% in 1991 and 16.5% in 1992) and the sixth leading cause of death for white women in the same age group in 1991 and 1992 (3.4% in 1991 and 3.8% in 1992). The death rate from AIDS was 12 times as high for African American women (38.0 per 100,000) as for white women (3.3 per 100,000) (CDC, 1993b). Among Latinas, AIDS was the third leading cause of death in this age group (12.4% of the deaths) (CDC, 1993b). However, Puerto Rican women have the second highest rate of deaths from AIDS cases among all women in all the states and territories of the United States (CDC, 1993c). They account for approximately 30 percent of all AIDS-related deaths among all women and all Latinas; in contrast, there is a much smaller proportion of such deaths among women of Cuban origin (9%), Mexican origin (2%), and other Latinas (6%).

Geographic features demonstrate further vulnerability to HIV/AIDS among women (CDC, 1992a). Ten metropolitan areas (including, New York; Los Angeles; San Francisco; Washington, D.C.; Miami; Chicago; Houston; Newark; Philadelphia; and Atlanta) account for more than half (51.5%) the reported cases among women (CDC, 1992a). In Chicago, between 1987 and 1992, the number of AIDS cases among women grew an alarming 1,500 percent, from 20 cases in 1987 to 317 cases in 1992 (unpublished data from the Chicago Department of Health). In Illinois, from 1991 to 1992, the number of diagnosed cases increased 47 percent among women, compared to a 14 percent rise among men, according to the Illinois Department of Public Health (1993). In New York and New Jersey, HIV/AIDS has been the leading cause of death since 1987 among African American women aged 15 to 44 (Chu, Buehler, & Berkelman, 1990). In Florida, HIV/AIDS in 1990 also became the leading cause of

death among African American women this age group (Conti, Lieb, Spradling, & Witte, 1993). Taken together, the AIDS morbidity and mortality figures suggest a disturbing trend: unequal and growing disparities in the rates among women. Although HIV/AIDS has affected women from all races, classes and walks of life, the majority of women with HIV are poor women of color (Springer, 1992).

Latinas and African American women are not only shouldering the greater burden of HIV/AIDS, but they are experiencing the highest poverty rates in the United States. Women and children make up the overwhelming majority of those living in poverty (Sidel, 1992). Three-fifths of all indigent adults are women (Taylor-Gooby, 1991). Equally ominous, poor women are more likely to live in officially designated poverty areas than are men (37% vs. 29%) (U.S. Bureau of the Census, 1992). Single female householders and single mothers have at least twice the poverty rates of their male counterparts, regardless of race or national origin (Goldberg, 1990). When compared to families headed by a single father, single-mother families had poverty rates that are approximately three times as high. According to the U.S. Bureau of the Census (1992), nearly one in two African American and Latina mother-child families lives in poverty. Among single African American and Latina mothers nearly two-thirds are poor (Miller, 1990). Women of color are also more disadvantaged in the labor market, receive less child support, and more frequently depend on sub-poverty-level assistance (Funciello, 1993).

Therefore, the risk to women today is heavily skewed not only by race/ethnicity, but by economic class, particularly in major urban areas (Hunter, 1992). In Philadelphia, for example, Fife and Mode (1992a, 1992b) identified a distinct shift, beginning in 1987 in the incidence and prevalence of AIDS from high-income groups to low-income groups. This phenomenon is also particularly evident in the poorest neighborhoods of New York City—today's epicenter of the HIV/AIDS epidemic.

The looming image of Manhattan as the center of commerce and culture often encompasses our view of New York City. But New York is not only Manhattan; it is also Central Harlem and

the South Bronx. Who has heard of the South Bronx neighborhoods of Hunts Point, Mott Haven, High Bridge, or Morrisania (Kornblum, 1991)? In these neighborhoods 5–10 percent of all women are infected with HIV (a seroprevalence rate that approximates those of some areas of East and Central Africa) (Drucker, 1992). In the Bronx, in 1993, women accounted for 28 percent (up from 22% in 1990) of all AIDS cases in New York City (New York City Department of Health, 1993). A closer view of the epidemic in New York reveals that the highest concentration of AIDS cases among women is in the extremely poor neighborhoods of the South Bronx, where one in four households has an annual income of less than \$7,500 (Drucker, 1992; National Planning Data Corporation, 1992). These are neighborhoods comprised almost exclusively of Latinos or African Americans (95%). Worse yet, in the poorest neighborhoods, as many as 69 percent of the women with HIV/AIDS acquired their infection through their use of injection drugs.

At the core of the current epidemiologic configuration of HIV/AIDS one finds a tight tangle of interconnected pathologies (Kuttner, 1991). Extreme poverty in these urban communities shows its face in high unemployment and underemployment, the lack of education, homelessness, inadequate health care and social support services, the rising rates of homicides and suicides, the resurgence of plagues and pestilences of yesteryear (including, tuberculosis, measles, scarlet fever, diphtheria, syphilis, and gonorrhea), fetal/infant mortality, malnutrition, repeated unwanted pregnancies, abandoned women who are heads of their households, emotional and social isolation, drug addiction in every form (including drug dealing as the only type of commerce), and later in drug-exposed infants, the multiplying deaths from AIDS, and high incarceration rates (Belkin, 1992; Gould, 1993; Wilson, 1993). Extreme poverty also shows itself in the urban landscape of burned-out and abandoned buildings (Wallace, 1991). Economic and political developments in the United States since the early 1970s have undermined the quality of life in inner-city communities (Gasch & Fullilove, 1993). Thus, social ills are increasingly becoming markers of the widening polarization between rich and poor in the United States (Gorman, 1993). In terms of the current

patterns of AIDS, growing economic and political disparities are propelling the unequal spatial and social propagation of HIV infection.

Two recent works, in particular, shed light on the relationship between the spread of AIDS and other diseases and social inequality, one published in the *Journal of the American Medical Association* (Adler, Boyce, Chesney, Folkman, & Syme 1993) and another from the *British Medical Journal* (Wilkinson, 1992). Both studies demonstrated that among developed countries it is the distribution, not the level, of incomes that matters most. And the United States is among the least egalitarian of the developed countries with respect to income distribution. The surge of inequality during the 1980s in the United States was evident in the dramatic resurgence (following two decades of decline) of tuberculosis ("the white plague") in impoverished areas of urban America. "Tuberculosis," Turshen (1989, p. 251) rightly notes, "is one of the best medical pointers to social inequality, and the trend in its epidemiology one of the best indicators of . . . inequalities." Incidentally, following two decades of decline, in the 1980s, New York City experienced a remarkable 132 percent increase in the incidence of tuberculosis (National Research Council, 1993).

So today material and economic deprivation constitute the overarching context of the epidemic, and the inner city is where HIV infection takes hold and thrives. Areas with higher rates of HIV/AIDS among women appear to be strongly correlated with other social problems, including low income, inadequate or insufficient housing, unemployment, low-birthweight infants, and low maternal education, to name a few.

The link between injecting drugs, social and material deprivation, and HIV is strong (Currie, 1993). Although as a society we seem so preoccupied with the sexual aspects of the AIDS epidemic, we ignore the problems of drug addiction and the social alienation and joblessness that precipitate the use of drugs especially among people of color (Staples, 1990-91). Although female injection drug users can be found in every social class and in every community in this country, the very high prevalence of drug use among poor women and its association with specific risk behaviors that are responsible for transmitting HIV

(such as sharing syringes and needles) are more often found in the most impoverished urban communities (Drucker, 1991).

The growing disparities in the risk of acquiring HIV/AIDS among poor inner-city women, accompanied by the high prevalence of injection drug use, must be examined within the context of the social fabric in which the infection takes hold and thrives (Bell, 1989, p. 9). The National Commission on AIDS (1992, p. 11) emphasized this point, "We would do well to take account of social forces and institutions that undermine individuals' capacity to adopt and sustain a healthy lifestyle." Thus, to understand the trend toward the feminization of the epidemic, it is critical that we also examine the trend toward the increasing preponderance of poverty among women. In his testimony on the duality of the HIV/drug epidemic to the the National Commission on AIDS (1991b, p. 14), Robert Fullilove advocated this line:

The one thing we know about poverty in this country in the last 20 years is that it has really altered the structure of many of the neighborhoods in the United States. Blacks and Latinas are increasingly concentrated in areas that are becoming poorer and poorer, and with that concentration has come a tremendous increase, not just in HIV infection, not just in the prevalence of drug abuse, but in a whole host of other serious social problems ranging from crime to just about anything that you can possibly describe.

The larger structural economic changes involving deindustrialization and hyperghettoization in the past 35 years, coupled with the "benign neglect" of the 1960s, the "planned shrinkage" of the 1970s, and the "systematic withdrawal of federal funds to support the safety net of hope and decency" in the 1980s, had a dire impact on inner-city communities and particularly on the lives of women who live in them (Gould, 1993, p. 133). Whereas the trend toward income inequality in the 1980s set the stage for the onset of the epidemic, misdirected public policy further enhanced and amplified the spread of HIV infection in the poorest urban neighborhoods. What went wrong with public policy? First, nothing hurt AIDS prevention activities with drug users more than the ill-conceived, extremely punitive, and harm

maximizing War on Drugs. Second, HIV prevention research and policy to date has focused disproportionately on the micro-level, namely, individual lifestyles (self-damaging lifestyles).

The Failure of the War On Drugs

The ill-conceived national War on Drugs of the 1980s greatly exacerbated the HIV/AIDS epidemic. It caused more fear, more arrests, more incarcerations, more disruptions of families, more economic ruin and homelessness, and more stigma and drove more users underground. Because of the emphasis on law enforcement, harm-reducing interventions that had been proved to work against the transmission of HIV in Europe, such as the exchange of syringes, maintenance of long-term drug users on their drugs of choice, and the improvement and expansion of drug treatment services, were ignored (Springer, 1992) (for a discussion of alternatives to the War on Drugs, see Ferguson and Kaplan, 1994).

Far from being a humane and pragmatic response to a public health crisis, the Reagan and Bush administrations' punitive approach to drug policy caused the most harmful drugs, such as crack, to be readily available and cheap, but the least harmful drugs, such as marijuana and pure heroin, to be expensive and hard to get (Springer, 1992). Equally ominous, laws prohibiting the use of narcotics and the possession of injection equipment made the practice of taking drugs extremely hazardous because of needle sharing (exposure to HIV) and the absence of quality control (drug impurities).

Under the Reagan and Bush administrations' war on drugs, policymakers ignored social and economic inequality and chose instead to focus on the use, abuse, and trafficking of illegal drugs as if they were the most severe and damaging social problems the country faced during those 12 years (Johns, 1992). The War on Drugs was used as a diversion from these other, more serious social problems, including HIV/AIDS.

Which facets of the War on Drugs increased women's vulnerability to HIV infection? First, the expense of waging war against drug users led to the acute shortage of harm-reducing interventions (including drug treatment on demand and massive

outreach programs) that would have helped contain the transmission of HIV. Moreover, to this day, there is a serious nationwide shortage of treatment facilities for women. In California, in 1990, of the 366 publicly funded treatment facilities, only 67 of them would treat women (Ferguson & Kaplan, 1994). In New York City, 54 percent of treatment programs surveyed by Chavkin (1989) excluded pregnant women on Medicaid, and 87 percent excluded crack-addicted women on Medicaid. And once in treatment, women too often face other critical obstacles, such as the lack of child care. For example, of Ohio's 16 treatment facilities for women, only two provide child care services.

Second, under "fetal endangerment" laws, many women nationwide have faced criminal charges and prosecution. Several states (including, Florida, Illinois, Oklahoma, and Rhode Island) have defined drug use during pregnancy as a form of "child abuse." The threat of arrest and prosecution on drug charges, however, does not appear to deter pregnant women from using drugs. Rather, the fear of arrest, prosecution, and incarceration usually discourages substance using women from seeking vital reproductive health care (Johns, 1992).

Third, there has been a dramatic increase in the female prison population. Due, in part, to mandatory minimum sentencing, from 1980 to 1989 the female prison population more than tripled to almost 41,000 (Hirsh, 1993; National Commission on AIDS, 1991). Drug violations accounted for most of this increase. Between 1983 and 1989, the percentage of women held on drug charges increased approximately 500 percent, from 2,243 to 13,426 (Harlow, 1991). By 1989, a higher percentage of female (34%) than of male inmates (22%) were in prison for drug offenses (Snell, 1992). Women in prison were more likely to have a history of drug use than were male inmates. Twice as many women (32%) as men had used a major drug (such as, heroin, cocaine or crack, LSD, PCP, or methadone) daily in the month before their arrest. As early as 1979, the General Accounting Office (GAO) (1979) estimated that 50 to 60 percent of female prisoners had alcohol- and drug-dependence problems, whereas by 1991 the estimates ranged from 70 to 80 percent (National Commission on AIDS, 1991a). Yet, state prisons have the capacity to provide drug treatment to fewer than 20 percent of the inmates who need it, according to the GAO (1991).

The War on Drugs clearly had a detrimental impact on women. The fear of arrest, prosecution, and incarceration, compounded by limited access to treatment, drove the problem of drug use underground for too many women; there they became exposed to numerous health threats, including HIV infection. Thus, unless current social and legal constraints on drug use are changed, the avoidance of arrest by sharing drug works will continue to be more important to "survival" than will changing behavior to minimize the risk of contracting HIV (Connors, 1992, p. 598).

The time is ripe for policymakers to redirect the resources of the War on Drugs toward more pragmatic and peaceful ends. A drug policy modeled after the Dutch experience with *normalization* (namely, treat drug abuse as a problem of social well-being rather than as a criminal matter) provides a blueprint that is more humane, and, because it is linked to better health and social services, more effective in reducing drug use and HIV infection (Ferguson & Kaplan, 1994). Consider this: In New York City it costs \$25,000 to keep a person in jail for a year, whereas for \$15,000 that same person could be kept in a residential therapeutic community where she or he would receive treatment and education in addition to room and board (Springer, 1992).

The Failure of Conventional Theories of HIV Transmission

Conventional theories of the transmission of HIV heavily emphasize the role of the individual and the need for individual responsibility. This is what I call the *behavioralization* of the HIV crisis. Transfixed by the ethic of personal responsibility for one's behavior, no matter the circumstances, the United States continues to place most of the blame for HIV infection on its victims and not on the society that is producing them. This approach prevents us from locating the causes of the problem and facing them squarely.

We are told that the only means by which people can protect themselves from infection, and prevent the further transmission of HIV, is to pursue behavior that avoids risk to themselves and others. "Unfortunately," Hart (1989, p. 128) wrote, "this has led to an emphasis, and sometimes exclusive focus on, individual

behavior as if that behavior were entirely voluntaristic and free from external forces, divorced from a social context of powerful influences not all of which are subject to simple or immediate modification." Most of the AIDS- prevention strategies are based on the assumption that the decision to engage in safer sexual or drug-using practices is an individual one. Writing in another context, Turshen (1989, p. 220) observed that this lifestyle view ignores questions of what causes behavior or why HIV is occurring at this particular historical conjuncture.

Lifestyle factors are cited by policymakers and health educators as the key to a healthier society. All that people need, argue the advocates of the lifestyle theory, is information about how to live healthily (for example, "wear a condom") for them to be able to make the right choices (Aggleton, 1991). Although it would be silly to contend that individuals have no choice in their actions, logic would indicate that policymakers also should examine how personal choice is constrained by adverse social structures and power relations. As Gena Corea (1992, pp. 294–295) argued emphatically:

Behavioral change, which is what AIDS prevention is about, is really a change in power relations between men and women. . . . This can't be promoted successfully if we don't . . . act on what I would call the structural determinants [of behavior] which are: poverty, poor housing, a lack of educational opportunities, acculturation problems, lack of health care.

Contrary to what lifestyle advocates suggest, powerful social forces, including class structure, sexual divisions, and traditions of the local economy, are conditioning drug-taking behavior. Specifically, how does community stress contribute to unsafe practices in the use of injection drugs? It is important to identify the endemic pernicious social and psychological factors that are far too prevalent in the lower social classes that, in turn, increase susceptibility to HIV and other diseases. Susser, Watson, and Hopper (1985, p. 254) argued that "economic hardship, frustrated aspirations, chronic insecurity about jobs, frequent disruption of social ties are all features of the lives of the poor." An explanation for health-jeopardizing behavior must take proper account of the endemic stressors that influence the

everyday lives and material conditions of inner-city women. In contrast to the prevailing individualist perspective, a social model must be applied that locates personal choice in the context of subcultures and their collective response to pernicious health-threatening social and material conditions (Ettorre, 1992).

I do not deny that the current exigencies of the HIV epidemic among women call for a more aggressive and explicit public education campaign. However, over the long haul, a broader public policy effort will have to be directed at the more general and complex problem of social inequality and its impact on poor and minority communities, including health care, housing, education, nutrition, transportation, guaranteed income, meaningful employment, and urban redesign (Kaplan, 1990). That is, reducing economic and social inequalities may be the only road to the achievement of a healthier and just society.

What I have argued in this article is that the threads that run through the AIDS epidemic today are deeply woven into the fabric of American society—social and sexual inequity, drug addiction, and racial discrimination and segregation, to name a few (Drucker, 1991, p. 62). Thus, efforts to change vulnerable lifestyles without altering adverse social structures may not only be ineffective, but may do more harm (by blaming the victim, for example). As a society, we can no longer afford to operate as if the fate of individuals who are at risk for HIV infection is solely an individual problem (Johns, 1992, p. 73). Our real challenge is to move beyond personal responsibility and to find ways to effect genuine changes in the sociopolitical system in an effort to reduce economically disadvantaged women's vulnerability to AIDS and other diseases of poverty. Faced with the alarming increase of HIV among women, the challenge for a civil society, then, is not only to discover how to halt the spread of HIV/AIDS, but how to create healthier communities in which all citizens can flourish. "The real control for the spread of HIV," recently wrote Gasch and Fullilove (1993, p. 188), "lies in rebuilding damaged communities so that they can function in a health-promoting manner. Without such broad-based, programmatic interventions, the continued deterioration of the inner-city will promote the spread of AIDS and other diseases, like tuberculosis, drug addiction, and violence."

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