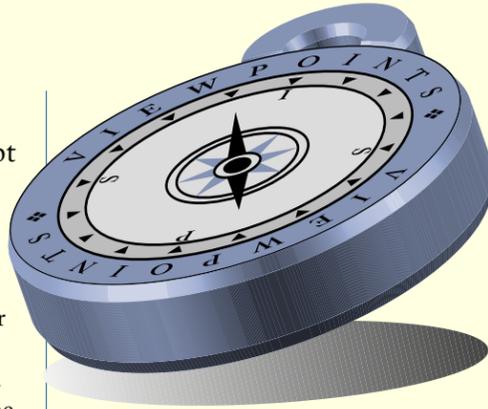


Rethinking Prevention: Some Lessons from HIV/AIDS Policy

“Prevention” is a key concept in public health—a concept which is often contrasted with treatment and used to signify a shift from a focus on curing diseases to a focus on preventing their onset. More fundamentally still, it is invoked to signify a shift away from a medical/clinical view of health and the biological and physiological causes of illness to a sociological approach that searches for cause in the social environment.

Yet, based on my experience in HIV/AIDS policy, this is a false dichotomy and it is problematic both from a policy and from a theoretical standpoint. The focus on prevention, at least in HIV/AIDS policy, has moved us only marginally closer to understanding how social context relates to disease. Also, the separation of biological and social causes that underlies the treatment/prevention distinction only perpetuates the view that the physiological and sociological aspects of the virus are independent of one another.

In HIV/AIDS policy two things are notable. First, AIDS prevention is synonymous with education; and the education emphasizes changing individual “risk behaviors.” Second, treatment is synonymous with services. Furthermore, the two are almost completely separate from one another with prevention/education activities targeted to HIV- individuals and treatment/services targeted to HIV+ individuals.



More Than Education

What is problematic about this? To be sure, it is important, on the one hand, to educate people about the behaviors which put them at risk for HIV infection. And, yet, from a policy standpoint we know from all sorts of health promotion campaigns that education is only moderately effective at changing individual behaviors. AIDS is no different.

I have spent the last three years working with a group of street working women in New Haven (mostly sex workers) who are either infected or at great risk of becoming so. These women know at least as much about HIV as I do, and, while they have changed their behaviors in some ways, they continue to engage in a frightening amount of risk-taking activity. It isn't because they don't know about the dangers. It isn't because they don't care about them or because they have failed to internalize the risk. Ultimately, it's because as poor women (often of color), engaged in illegal activity, they are relatively powerless to act on their knowledge.

They live, as I do, in a society premised on gender, class, and race inequality in which women's economic

options are limited, in which women daily face the threat of violence, in which most routes to power are structured according to the needs and realities of white middle- and upper-class men. It is this social system of inequality that puts them at risk for HIV more than any single type of risk behavior. When a client offers an extra \$20 to a woman not to use a condom (as many do) and this is her sole source of income, or when a partner threatens to beat her if she asks him to wear a condom, she won't use it—in spite of her knowledge of the associated risk.

Our policy approaches to HIV/AIDS prevention, then, are flawed because from a theoretical standpoint they are constructed on misplaced assumptions about the sources of the virus. Although the shift to prevention is touted as moving us from a physiological to a social view of the causes of the virus, it has instead, involved only a slight variation on the biomedical model. Through it, individuals are asked to change their behaviors so that the biological agents of disease won't get the chance to operate.

We show that we do not truly understand how social context relates to HIV risk when we fail to ask for an end to advertising campaigns that market sex for corporate profits, the eroticization of violence against women, the devaluation of women's work and the work of people of color, or racism, homophobia and sexism in the organizations through which power is accessed.

To consider this social structural definition of prevention may seem a

tall task, and it is, though this makes it no less worth the undertaking. Still, there is a simple way to reduce the risk of HIV in the everyday lives of the women with whom I work: provide them with resources. Women who are more economically independent may not have to sell their bodies for sex, or at least, may have more control of the conditions under which they must do so. Women with options for food and housing may be able to leave an abusive living situation.

Targeted Treatment

This brings me to my second concern with HIV/AIDS policy, namely, the separation of education/prevention from treatment/services and their almost exclusive targeting to HIV- and HIV+ persons respectively. The implications of this approach are clearly expressed by one woman I interviewed when she said: “It's great now. I'm eligible for a clothing allowance so that I can get a winter coat. ... I haven't had a winter coat for so long. What kind should I get. ... And when I get my apartment I can get a furniture allowance to get some nice things. And the apartment, now I'm eligible for emergency housing. Maybe it's a good thing I got the virus. I couldn't have gotten these things before.”

This woman's observations are consistent with data that we have been collecting from drug-using women with or at risk for HIV which show that HIV- women are 1.6 times more likely than HIV+ women to identify barriers to social and medical services (See Thompson, Blankenship, Winfrey et.al. 1994). Yet it may be that fewer women would become infected if they had access to such services.

To be sure, it is important to provide services for HIV+ individuals. But because gender, class and race inequality and lack of power are contributing causes of HIV, it's as important to provide services to HIV- individuals as it is to provide them for HIV+ persons. They are as important as education in HIV prevention. The resources such services can sometimes provide have the potential to shift the balance of

power, at least in the everyday lives of some, and thereby reduce their risk for HIV.

This is not to suggest that the social service model of addressing problems is necessarily an empowering one or that providing access to services alone will attack all of the social structural causes of HIV. But I am not the first to acknowledge that social welfare programs can have an impact on

Piven and Cloward argue in the *New Class War*, for example, that the dismantling of the welfare state is in part an attack on the working class. For welfare alters the bargaining power of workers, providing them with an alternative, however meager, to low wage, unsafe, or otherwise undesirable jobs. Zillah Eisenstein contributes a more gendered understanding of the process, noting that women comprise the majority of both welfare recipients and workers in the welfare system. Thus, an attack on this system is an attack on women and whatever power they may have gained through the system.

Reinforcing Wrong Ideas

When we separate education from service, prevention from treatment, we reinforce the view that the causes of HIV are individual lifestyles and behaviors—not social structures of inequality. We do something else as well. We perpetuate the idea that the biological causes of disease are independent of their social sources.

I was particularly struck by this while participating in the development of a grant proposal to study the “natural history” of the HIV virus in women. Although my clinician colleagues had no trouble with the concept of “natural history,” it was hard for me to imagine the possibility that there existed some purely biological source of this horrible pandemic, the natural course of which could be charted through some carefully designed research project and then used as a standard against which

to evaluate each particular experience of HIV. Even if such a natural history did exist, how could we ever come to know it completely given that the world of the scientists studying this virus is shaped by the same structures of power and inequality that shape the world of those infected by it?

It seems to me that the biological and the social are inextricably linked and we do ourselves a disservice by offering up prevention as the socially aware alternative to focusing on cure and treatment. To be sure, we should seek with all our might to prevent the spread of HIV and other diseases. But prevention can mean different things and does not per se guarantee a more socially situated understanding of HIV or health more generally. Conversely, we may want to spend money and time in search of a cure, but such searches and the cures they generate will never be independent of the social context from which they emerge. If we ever want to curb the spread of HIV, we must transcend the prevention/cure dichotomy and develop an approach that understands the sociological aspects of both.

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