
Black Women's Risk for HIV

Rough Living

An Excerpt

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DEDICATION

In loving memory of

Irene Ferguson (1910–1981), my maternal grandmother

In loving reflection of the African-American women who have guided and nurtured me through the years. You were my first black feminist teachers and your examples by living lives of survival against seemingly insurmountable odds are by far greater than any other intellectual or theoretical lessons.

A special thanks to the women in the Rough who granted me access to their lives. One in particular trusted me enough to make me a part of her “change team” and I am forever grateful.

A special dedication to Henry for the way you stepped up to the challenge of loving, learning, and leading me through some “Rough” times of my own. Together we can do all things because we are strong through Christ who strengthens us.

Finally, this book is written under the mentoring of my mother and other mothers in my life including my birth mother (Clara), my godmother (Lillian “Matoo”), my aunts (Inez, Mary, Pauline, Mattie, and Leannia), and my community mothers (Mrs. Sanford, Mrs. Washburn, Ms. Lane, Mrs. Manner, Mrs. Ammons, Ms. Duncan, Mrs. Bentley-Grier, Dr. Buggs, Rachel Alexander, Rita Culver, and Betty Smith). Your guiding principles at key points in my life were extremely significant in shaping me to be the woman I am today.

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FOREWORD

Around the same time that many believed that no infectious disease was going to challenge medical sciences biomedical advances, the HIV/AIDS epidemic emerged. Challenges arose, as it turned out to be difficult to identify the constantly mutating virus that causes HIV/AIDS as well the variety of signs and symptoms that make up the syndrome. During the early 1980s, a test to identify infection with the human immunodeficiency virus (HIV) was developed. The expectation was that a cure would follow soon. However, finding a cure has proven to be much more difficult, and well into the third decade of the HIV/AIDS epidemic, no effective vaccine has been identified. The furthest we have come is to have treatments that slow the progression of the disease, thereby changing it to a chronic condition.

Initially HIV/AIDS largely was viewed as a syndrome that impacted select populations. Among these were men who engaged in sex with other men and users of illicit drugs. These so-called risk groups involved human beings who already faced stigmatization in society. However, as it became clear that not all members of a specific risk group became infected, the language shifted to risk behaviors. Whereas this may be perceived a positive trend, it also resulted in blaming those who became infected for their status. Exceptions were made for those individuals who belong to risk groups, such as persons who became infected through a blood transfusion or persons who were engaged in mainstream sexual relationships and whose partner caused them to acquire the virus. Interestingly, the notion of risk behavior and the associated blaming did not apply to them.

As we have entered the twenty-first century, a common route of HIV transmission is through unsafe heterosexual contact. Among those who became infected through unsafe sex, an overwhelming majority are women. Moreover, they tend to be women of color who reside in poor inner-city neighborhoods in metropolitan areas across the southeastern United States. Whereas the Centers for Disease Control and Prevention and other agencies have been reporting on this trend for close to a decade, few initiatives have resulted in effectively curtailing the spread of HIV among such women. As Gentry points out, those women most impacted by the HIV/AIDS epidemic tend to be black and poor, and they have limited resources. She describes how gender, race, and class intersect but also how few risk reduction interventions have taken this reality into consideration.

Gentry's monograph focuses on African-American women who reside in the Rough, a typical inner-city neighborhood like so many others in the United States. Once a supportive community, the members of which were actively engaged in the Civil Rights Movement, the Rough has become a community lacking in social capital. It is characterized by a crumbling physical and social infrastructure. The Rough became the site of a community-based HIV risk reduction intervention targeting African-American women who used illicit drugs, specifically those who smoked crack cocaine or those who injected drugs such as heroin or cocaine. This became known as the Health Intervention Project (HIP). Working toward her doctoral degree in sociology, after having utilized her M.B.A. degree in the business world, Gentry was eager to apply her newly acquired theoretical and methodological knowledge. This monograph is an extraordinary high-quality product to emerge from her dissertation research. Initially, she became one of the HIP intervention specialists and interviewers. She describes how two weeks into the project she recognized one of the HIP women as a former eighth-grade classmate. This motivated her further to understand what was happening, and more importantly, to learn what needed to be done.

Gentry brings years of personal experience, extensive knowledge, and excellent research skills to this monograph. In *Black Women's Risk for HIV: Rough Living* she reveals an outstanding sociological imagination. She does not shy away from applying her sociological insights to “real life.” Based on her ethnographic inquiry that included participant observation, mapping, and interviewing that is guided by a black feminist perspective, she presents a paradigm for HIV risk reduction that is grounded in the women’s perspective. In doing so she highlights the importance of considering the historical journey of African-American women in the United States, including the role of the church and the women’s approach to religiosity and spirituality. She specifically highlights the importance of agency among African-American women, a perspective that often is ignored and a trait seldom associated with disempowered and poor women. In doing so, Gentry also recognizes the complex set of social roles most women typically occupy, including the associated role strain. For example, she explores the women’s role as family members and the impact of the women’s family or origin of their current functioning as well as its role in terms of social support. Next, she highlights the women’s roles, such as being a partner in an intimate relationship and being a mother. By recognizing the women’s agency and their social roles, HIV risk reduction interventions need to build on the existing agency and provide advocacy. In addition, such interventions may gain from including family members and partners. This approach also links the women’s individual circumstances to the larger social context, including the community in which they reside and its characteristics as well as structural and policy influences. Gentry takes a refreshing look at the phenomenon of the devastating impact of the HIV/AIDS epidemic on poor African-American women. She challenges our assumptions about the women’s lives, including the presumed reasons for their weak positions and our biases in terms of their potential for a brighter future. This book is a treasure for scholars in disciplines such as sociology, anthropology, psychology, and public health as well as for social and health service providers and policy makers.

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Dr. Sterk and Dr. Elifson were the Principal Investigators for the NIH’s National Institute of Drug Abuse study that funded the research for this ethnographic project.

PREFACE

I started my journey into the Rough as part activist and part scholar to make a difference in the lives of high risk women for HIV. But somewhere along the way, each client made a difference in my life. As these women were at risk for HIV primarily due to their substance abuse issues, I recalled the first time that I even heard the words HIV/AIDS and crack cocaine as an inner-city adolescent. Today, I am not HIV positive, nor have I ever smoked crack cocaine, these two social and health epidemics are very much part of my personal history. Every woman I worked with caused me to re-examine my own behavior and come to accept that while my outcomes were different, my environment and experiences had been similar to many of the women at risk for HIV. What I learned through these discussions is that black women are talking tough, but living rough. Living rough in terms of trying to make sense of love and intimate relationships as grounded in trust and honesty. Yet, we are told to begin our relationships with discussion about condom use and HIV/AIDS status. Our pool of eligible bachelors has become a cesspool of black men who are disproportionately either in prison, on parole, or probation. So we talk tough about safe sex in theory, but our practice is very rough and often leads to risk that we are afraid to admit happened to us. The women whose lives are represented in this book highlight the need for us to redefine ourselves as empowered black women with high levels of self esteem and self worth that gives us the courage to tell the truth about our lives and how rough it really is to navigate love and relationships.

We have heard for years that the faces of HIV/AIDS have changed; yet we fail to consider that the factors leading to risk are as different as the diverse faces. Just as the faces and factors have shifted, so too has the blame. We blame the continued spread of HIV/AIDS in the black community on those with the least resources and power to fight back individually and structurally—poor black girls and women. Since completing my research, I have embarked upon a fight of my own—that of helping black women who do not smoke crack understand that our risk factors are entangled with those of our sisters with fewer resources. As long as we are looking for love in the same places, our lives are forever inter-related. Throughout my childhood, I remember hearing and church and school that I was special, unique, different, gifted, smart, and destined for greatness. At the same time the messages from my family was that “I wasn’t no better than anybody else”, that I talk too much, too loud, and was too fast. At one point in my life I felt that these were conflicting messages.

The women in the Rough helped clarify the ways in which both messages could co-exist. Messages that I was unique sent me searching for ways in which my life and experiences were different from the women I worked with as part of this clinical intervention. At the same time, messages from my family that I was no better than anybody else humbled me to look for ways in which my everyday life past and present was like that of the women in my study. I cannot imagine how my life would be different or similar to the women in this book had family, church, school, and community failed me in my childhood. Like some of the women in the book, my life started out in dire poverty. Yet, unlike many of them, I was socially secure with a stay at home grandmother who with only a fourth grade education taught me to read and write at the age of three. Like many of these women, I have compromised myself worth in search of intimate love. Yet, unlike many of them, I never had an intimate partner to offer me crack cocaine. My senior year, destined for college, valedictorian, participant in church activities, voted best all around by the faculty, and most likely to succeed by the senior class, scholarships waiting on me at several top ranking colleges, having heard the Nancy Reagan slogan of just say no—I still said yes to my drug dealing boyfriend who said, here, smoke this. I can only imagine what my life would be like today had that been a good experience and I liked it. As it turns out, I just didn't get it. My two good girlfriends growing up tried to get me to drink wine coolers, but my stomach ached to the point that I just didn't get it. So, it wasn't that I didn't try alcohol and drugs, or unprotected sex; I just didn't get caught up. Perhaps, choosing to believe the messages that I am special resulted in self-fulfilling prophecy overtime, but it did not guarantee that I would not give in to high risk behavior. However, when I challenge other “mainstream” women to rethink their past and present risk factors for HIV, many choose to lie, deny, or clarify why their lives are nothing like my client's lives. Paradoxically, their choice to remain silent or not search for common ground actually increase their chances of becoming infected.

Hearing such conflicting messages made my attempt to make sense of these new vocabulary words very painful. By the time I reached my senior year of high school, the conflict had gotten the best of me and the confusion turned to outright anger. I left Atlanta in the Fall of 1986 with literally the clothes and books I could carry and vowed never to come back to a place where HIV/AIDS, crack cocaine, and Reaganomics lived. At this time, the faces of HIV/AIDS were white or male as they were explained to me as a fourteen year old. At crack cocaine users were bad black males that I should not date or associate with according to all of my socializing agents. When I got to TCU, the conversations about HIV/AIDS and crack cocaine ceased almost immediately. But as a political science and history major, the debates about Reaganomics were part of my everyday life. I defended hard working poor people

as Reagan supporters on this issue overwhelmingly demonized poor women in particular. I knew I was destined to defend those who couldn't fight for themselves when after 4 years of fighting republican students, professors, and professionals, I left Fort Worth for DC unwavering on my perspectives about poverty, mothers on welfare, and a political disposition that embraced equality and compassion for the less fortunate.

So by the time I arrived back in Atlanta and accepted the opportunity to work in the Rough, little did I know I was in for the fight of my adult life-both personally and professionally.

I have never been one who felt I had a right to remain silent, nor have I backed down from a fight for something I really believe in. As such, this book is grounded in my belief that I should speak out about what I learned about direct and indirect risks for HIV. As I continue to look for ways to combine activism with scholarship, this book is merely a stop along the journey to learning how to tell black women's truth in a way that produces knowledge about us from us, raises our consciousness about issues impacting all black women's lives, and empowers us to act out against anything that affects some of us directly and others of us indirectly. Until all black women have voice, I am my sister's speaker and I speak the truth about black women's risk for HIV.

CHAPTER 1

Introduction: This Is the Rough!

I don't think anything going to be able to happen to change the situation in this community because it's just the way it is. This how this particular part runs. It's going to be like this from now on. This is the Rough!

Punkin, a 25-year-old HIV-positive crack cocaine user and seller, sex worker, and mother of two

THE ROUGH AS A HIGH-RISK ENVIRONMENT

Punkin is a 25-year-old crack-addicted and HIV-positive sex worker who arrived in the Rough in the early 1990s as a high-risk adolescent fully engaged in the sex and drug behavior that ultimately led to her being infected with human immunodeficiency virus (HIV). By the time Punkin arrived in the Rough, long gone were the images and symbols of the neighborhood as one in which middle-class black families raised successful children, ran profitable businesses, and participated in the desegregation movement, as many of the civil rights leaders lived in and around the Rough. The Rough that Punkin came to know in the early 1990s consisted disproportionately of poor, law-abiding, residents lacking resources for upward mobility. Others who remained in the Rough included the elderly and two generations of crack users and sellers. Moreover, many houses that were vacated by the upwardly mobile in the late 1970s and early 1980s evolved over time into abandoned houses and ultimately became known as crack houses. Still, there remain the boarded-up buildings, schools, apartments, businesses, and churches that provide evidence that at one time the Rough consisted of black families living relatively decent lives raising relatively decent children. Punkin's assertion that the Rough will not change from being characterized as a high-risk community is based on the fact that the Rough has served as the hub for chronic drug users and sellers for generations. Even in the midst of middle-class families, a few concentrated blocks of the Rough have always been infamous as an illegal drug supermarket corridor. Before the onset of crack cocaine, however, decent families dominated the Rough and held the hard-core drug sellers and chronic drug users to a few blocks of operation. In fact, because of the Rough's close proximity to the Atlanta University Center, made up of five historically black colleges and universities, it was not uncommon prior to segregation to find black lawyers, professors, doctors, nurses, teachers, and clergy literally living next door to factory workers, janitors, maids, and cooks.

After the civil rights movement's major victory of desegregation, many upwardly mobile black families took flight to the suburbs, leaving the Rough with limited community leadership and role models,

and over time left those remaining African Americans more isolated and devoid of formal and informal infrastructures (Massey and Denton, 1993; Staples, 1999). As there were limited efforts to restore the infrastructure, economic opportunities lessened and the socialization of children and young adults was seriously disrupted. According to Wallace (1993), “This [diminished socioeconomic opportunities] interacts with drug dependency, multiple sexual partner activity, poor access to service and resources, wider social discrimination and a palpable lack of political power to make such neighborhoods vulnerable to the rapid spread of HIV.” Wallace’s theory of the relationship between disintegrated neighborhoods and the spread of HIV is applicable to the Rough. The women who grew up in or near the Rough, in particular, express a deep concern that the Rough has become more fragmented and disenfranchised over time. Today the Rough suffers from chronic drug use and unemployment, as well as soaring cases of HIV/AIDS (Acquired immune deficiency syndrome), destruction of housing in the poorest areas, and high concentrations of homelessness. Moreover, the demise in infrastructure has resulted in limited community-based social services in the Rough to respond to the HIV/AIDS dilemma.

As I started to make some sense of how the Rough was one of many urban neighborhoods where HIV/AIDS is taking a toll among African-American women, I wanted to have a better understanding of structural conditions that contribute to the continued spread of HIV. While a comprehensive macro perspective on the social conditions of the Rough is beyond the scope of this book, I believe it is important to highlight some of the structural forces that exist and shape the Rough as a high-risk environment. According to the U.S. Census Bureau (1990) the Rough is a “ghetto poor” neighborhood because more than 40 percent of its largely African-American residents live below the poverty line. In fact, census tract level data revealed that in the 1980s the Rough had a poverty rate of 79 percent among a population that is 97 percent African American. Some ten years later, the 2000 U.S. Census Bureau, reporting on U.S. trends in the 1990s revealed that the poverty line for the Rough was reduced to 41%. Clearly this is due to a number of social and economic policies aimed at eliminating concentrated poverty in inner-cities throughout America. In fact, rather than uplift the poor, social policymakers opted instead to uproot the poor. Social policies such as welfare reform and the deconstruction of public housing in exchange for mixed income developments in fact resulted in lower rates of poverty in the Rough. However, without concerted and deliberate efforts to track the paths and socio-economic outcomes of families and individuals leaving the Rough, social policy analysts are unable to successfully conclude that social and economic policies actually reduced the number of individuals classified as ghetto poor. But rather through the phenomenon of gentrification, what we do know is that the number of middle class and white individuals living near the Rough increased from 1990 to 2000 in ways that would result in lower percentages of people living in poverty.

The urgency of addressing black women's risk for HIV is rooted in the devastating consequences of social and economic policies that ultimately led to the black feminization of poverty. This phenomenon sent poor black women scrambling for economic and social survival resulting in heightened risks for HIV infection. To put it bluntly, the black feminization of poverty is a phenomenon in which mainstream America directly and indirectly supports policies to push black women off welfare, put them out of public housing, and place their children in foster care. At the same time black women are becoming poorer and more desperate to maintain on the socioeconomic margins, there is a steady rise of new cases of HIV among black women.

Today, the black feminization of poverty manifests as a key factor explaining why black women are experiencing unprecedented new case of HIV. Recent CDC (2005) data show that HIV/AIDS is now the leading cause of death among younger African-American, who are between the ages of 24 and 35 and at higher risks for heterosexual HIV transmission. Closely related, HIV/AIDS is the third leading cause of death for black women between the ages of 35 and 44; and the fourth leading cause of death for black women between the ages of 45 and 54. As it is clear that black women are at risk for HIV over the life course, it is extremely important that researchers move black women from the margin to the center as it relates to implementing prevention intervention programs.

By the time the HIV prevention program known as HIP (Health Intervention Project) was implemented in the Rough, this program proved too little, too limited, and too late to help Punkin, as she was already HIV positive when I met her. But for many other high-risk women, they demonstrated that despite seemingly insurmountable odds, it is possible to change one's high-risk behavior in Rough-like environments. Punkin's story, however, highlights how the lines of personal responsibility and public accountability are blurred as it relates to how high-risk children are left behind socially, economically, mentally, and educationally. Just as in Punkin's case, once high-risk and socio-economically disadvantaged youth transition into adulthood, blame subtly shifts from the structural constraints to individual choices, as it becomes easier to blame adult women for their own troubles. Perhaps Punkin's own sociological imagination is guiding her thinking as she provides an honest and scathing critique of the Rough when she declares that nothing can be done to change a Rough-like community. As I pondered Punkin's pessimistic perspective, I began to think of how one eats the proverbial elephant—and that is one bite at a time. In this way, changing the Rough may be a larger undertaking requiring additional capacity building at multiple levels among diverse stakeholders. In the interim, however, we can change one life at a time by working intensely with high-risk women before they approach Punkin's plight of being crack addicted, HIV positive, and serving as sex workers in a high-risk community. While changing the Rough may be beyond the scope of most HIV prevention interventions, I do believe that by changing

individual high-risk women's behavior, we have taken the first bite in changing the structure of the Rough.

FACING MY OWN ROUGH REALITY

I remember the day that my experiences became real and surreal in a way that intensified my personal and professional commitment to HIV prevention education and research. Less than two weeks into my applied research position on the study, I was pulling client files in preparation for the scheduled HIV prevention interventions. My heart dropped as I came across the name of one of my high school classmates who was a former client of the program. Having grown up myself in a Rough-like neighborhood less than two miles from the Rough, it did not surprise me that I would discover I knew some of the clients. However, I was not prepared for the client file I came across belonging to a fellow honor student. I was sure it would have been the file of one of the girls from our high school who either dated drug dealers or had one or even two children upon graduation, or who had dropped out of high school altogether before our class graduated in 1986 during the heart of the “New Jack City” era. In essence, I would have predicted that the HIV prevention intervention client file I discovered would belong to a girl at the bottom of our class, or even to one who had been unengaged in extracurricular activities. Perhaps I would not have been as outraged if the file was that of a woman, who as a teenager was already using the gateway drugs of alcohol and marijuana or of a girl who appeared to have no curfew and limited parental controls growing up. I would have expected the file to belong to one of the girls in my class, who at fifteen and sixteen years of age flaunted the fact that they were dating men in their twenties and thirties. In essence, the sociologist in me wanted to confirm what I had learned about the predictors of negative outcomes for high-risk youth, and in this way, I remained stunned that the client file didn't belong to any of the girls having the high-risk behavioral patterns that are often discussed as the precursors to adult high-risk behavior. For a brief moment, I even realized that this could have been my file.

This file, however, belonged to Nicole, a classmate I met in the eighth grade when I sat next to her in the clarinet section for both marching band and concert band seasons. In fact, during band competition, Nicole played an alto clarinet solo that received high praise from the judges and our fellow band mates. Nicole sang inspirational solos at many school assemblies, and I typically introduced the guest speaker. Right before the speaker would take to the podium, Nicole would render a motivational song—no easy feat in an inner-city school where the students were sitting on the edge of their seats to imitate the *Show*

Time at the Apollo audience when they boo performers that fail to measure up. But Nicole had a beautiful soprano voice that only drew praise and applause at the end.

In addition to her strength as a soloist, Nicole grew up in a neighborhood church, and her mother worked as a paraprofessional at our school and was relatively active in the school's PTA. However, reflecting back, I do recall some hints of low self-esteem in Nicole's life. Nicole had a very bad skin problem and appeared to go overboard to be accepted by the "in-crowd." I remember as freshmen during band hazing week, she was the only freshman to follow through on the ridiculous requests and assignments given to us by the upperclassmen. Perhaps her unaddressed issues concerning self-esteem might explain why, after leaving our Rough-like community in pursuit of higher education, Nicole would succumb to peer pressure within the drugging and drinking community. In our inner-city school Nicole and I were among 7 students in a graduating class of 145 that would at least start college in the fall of 1986. As I left for Texas Christian University in Fort Worth, Texas, Nicole remained local and attended a historical black college on the edge of the Rough, and unfortunately found herself in the heart of the Rough and fully participating in the high-risk behavior that she had managed to avoid for at least the first eighteen years of her life.

After getting over the initial shock and hurt of discovering Nicole's file, I finally got up the nerve to inquire about her whereabouts, as the outreach workers were known to maintain contact with the clients long after they left the HIP program. Although it was bittersweet news, I found some satisfaction in learning that Nicole had been in a drug rehabilitation program for the last twelve months. While I was relieved that Nicole was a success story in the HIP program, I was deeply disturbed and saddened that one of my classmates who had remained resilient in our Rough-like community had somehow ended up in the Rough. This feeling of despair prompted me to explore the theme of how do girls from decent families find themselves facing the same Rough dilemmas that mainstream society continues to associate as negative, yet predictable, outcomes primarily reserved for girls who grow up in the streets.

I felt relieved that the HIV prevention intervention had resulted in Nicole entering into a long-term drug treatment facility. Once I began transporting my own clients to drug treatment as part of the intervention process, one of the outreach workers arranged for me to see Nicole. She gave me a huge heartwarming hug and shared with me that the HIV prevention program had saved her life. Unfortunately, however, Nicole's file would not be the last one I would run across from my old classmates, as I would discover other clients who were high school cheerleaders, athletes, members of the academic top ten, and homecoming court queens. As I moved deeper into the Rough as an outreach worker and behavior interventionist, I discovered even more of my former schoolmates selling and using drugs, living in crack houses, and participating in sex work. For me, locating both categories of classmates sparked a sense of

urgency that we must intervene in the lives of high-risk women at risk for HIV infection much earlier and more intensely.

Nicole's story resembles that of many of the women in this book who do not fit the stereotypical "bad girl to bad women" transition. Like Nicole, many of them grew up in relatively stable households where one or both parents worked. These women would not have been flagged as at-risk youth, as many of them participated in extracurricular activities, attended church, worked after school and in the summers, did not get pregnant in high school, received high school diplomas, and went on to be gainfully employed on living wage jobs.

At the same time, there is another group of women that was born into families that have been labeled at risk for two or more generations. Many are the offspring of prostitutes, pimps, drug dealers, and drug users; and having been born and raised in Rough-like environments, they grow up to view high-risk activities as the norm. In the end, however, no matter whether they grew up as decent or street girls, the women now find themselves living and coping to various degrees in this high-risk environment.

The challenge for HIV prevention researchers and practitioners is to face our collective reality that the faces and factors of new cases of HIV have changed with current HIV prevention interventions programs under-equipped to address the complexity of issues new clients present (Gilbert, 2003b). Rather than seek simple solutions, we must be willing to reach inside each woman and help her tell her own story in a way that empowers her to be a change agent in her own life. No longer can we afford to treat black women as a homogeneous group of high-risk women confined to high-risk communities. The challenge for the HIV prevention community is to invest in intervention processes that support examining each woman's unique background and circumstances that resulted in her present-day conditions. In an attempt to contribute to the theory and practice of such a paradigm shift in the HIV prevention community, I have included strategies and tactics at the end of each chapter in this book about how to respond to the unique differences that manifest among a group of women who have been objectified largely as a monolithic group of high-risk individuals.

BACKGROUND OF THE HEALTH INTERVENTION PROJECT

The ethnographic findings presented in this book are based on a larger study entitled The Health Intervention Project (HIP), which was implemented by Atlanta-based researchers with expertise in public health and sociological perspective. The HIP House—as it was affectionately known—addressed the idea that poor African-American women who smoke crack need more effective community-based (as opposed to institutionalized) HIV prevention programs to address their high-risk behaviors. Between 1997 and 2000, the staff enrolled over 400 drug-using African-American women from an at-risk neighborhood in Atlanta, Georgia, aiming to fill several gaps in HIV/AIDS prevention literature as it relates to the impact of race, class, and gender in the lives of poor African-American women who also use drugs and are at risk for HIV infection. An added benefit of having this program in the community was that it provided insight on how risk reduction programs both succeed and fall short in urban poor communities with scarce resources.

The women who participated in the ethnographic interviews were recruited from among a group of women who completed the HIP Project. The geographical location for the HIP House was initially an apartment in a housing project where the demographics of the residents matched those found in the census tract for this ghetto poor neighborhood. About two years into the study, the HIP House was relocated to a house approximately five blocks from the original apartment. At any given time, the core HIP House staff consisted of a program director, two to three interventionists, two interviewers, and two to three street outreach team members. Initially, evening and Saturday work were common. The schedule shifted as the project evolved and the staff changed. Toward the latter years, the HIP House operated Monday through Friday from 9:00 a.m. to 5:00 p.m. In addition to the full-time staff, there were several graduate students and community consultants who worked part-time over the course of the project. While there were key roles and responsibilities assigned to staff members, everyone participated in street outreach, as well as in food, clothing, and condom distribution (Sterk and Elifson, 2003).

The HIP risk reduction program was implemented in six key phases. The formative research phase one included a diverse team of street outreach workers, health educators, graduate students, and the co-primary investigators, who worked to develop a comprehensive perspective of members of the target population. In phase two, street outreach team recruited high-risk African-American women to participate in the study. Next, phase three consisted of women participating in a baseline interview and pre- and posttest HIV counseling. They were then randomly assigned to one of three risk reduction interventions: a standard session or one of the enhanced models known as the motivation, or negotiation, sessions. In phase four, women participated in a post intervention session administered after their intervention to determine short-term changes in high-risk behavior. Women were contacted six months after their

intervention as part of phase five to measure longer term impacts of the HIV/AIDS prevention intervention. Phase six included the ethnographic interviews and a follow-up HIV test (Sterk and Elifson, 2003).

Each woman was given fifteen dollars for a baseline interview, twenty dollars after the post intervention interview, and twenty dollars for the six-month follow-up interview. The total monetary incentive for each woman completing the study was fifty-five dollars. No money was given for intervention sessions. However, the participants could request food, bus tokens, clothing, condoms, hygiene packets, or assistance with referrals during those appointments. Additionally, program graduates were allowed one visit per month to get food and clothing. In the final phase of the project, forty-five women were asked to participate in a qualitative interview and were given an additional fifteen dollars. In addition, other incentives for women who allowed me to observe them in the field included cigarettes, condoms, food, and transportation to various social service providers.

ETHNOGRAPHIC RESEARCH METHODS

Participant Observation

Participant observation served as a key approach to observing and mapping risk in the Rough. This ethnography draws heavily on observations during my fieldwork as a graduate assistant and as an employee of the HIP Project. For the first four months I conducted baseline, post intervention, and six-month follow-up interviews. By my fifth month on the project, I became an interventionist responsible for my own clients. During my time at the study site, I helped distribute food, condoms, and clothing. In addition, I assisted some of the women in gaining access to various social services and community outreach programs. Over time, I became personally involved in some of the women's lives, including interactions with their extended families, steady partners, and children. In fact, I continue to maintain contact with some of the women I met during my time at the HIP House.

Participant observation also served as a key strategy for getting into the neighborhood after working hours. Extending my observations to weekends and evenings gave me more of an insider's perspective of the everyday realities of poor African-American women who use crack cocaine. Initially, I depended heavily on the street outreach team to introduce me to people in the area, and I adhered to whatever role they assigned me. Most of the time they presented me as a new "girl" at the HIP House who would be helping the women out.

Just as Whyte (1981) warned, it is far better to allow gatekeepers to introduce you and do the talking in the earlier periods of fieldwork. Once I had been associated with the HIP House for about three

months, however, I was quite comfortable picking up clients and dropping them off alone, and I often used this time to establish rapport with the women. Most seemed disappointed to find out that I never used drugs and was not in recovery, but they continued to talk about past and present experiences. My lack of experience may have limited my ability to relate in some instances, but it also may have allowed some women to open up as they took it upon themselves to “school me” concerning the realities of street life. Even though most did so describing “other” women’s behavior, such conversations provided an insider’s perspective on general trends and patterns of everyday life in the Rough.

I was able to “code switch” depending on the field setting (Anderson, 1999). For example, among drug dealers who could help locate women, I took on the role of “concerned interventionist” willing to go into any crack house or rooming house to find a client for an appointment. As I was keenly aware of the perceived and real power the dealers have in the community and the danger they may pose for not respecting their “corner,” I always made a point to talk to them and tell them exactly what I was doing.

In the evenings and on weekends I often played the role of “street-smart former housing-project girl,” dropping names and mentioning associations with some of the “high rollers” with whom I grew up. Sometimes I just hung out on various corners with women from the HIP Project. Over time, the drug dealers were comfortable with me and proceeded to transact business in my presence. In any case, I was careful to downplay any connection with drug treatment or pass any moral judgment on the activities I observed, as this may have resulted in cold treatment or maltreatment if the dealers had taken my comments personally or felt I had the potential to hurt their business.

In my initial association with the HIP House, I had no intention of using my research experiences as the basis for a dissertation project. I had come to graduate school to study and improve the lives of at-risk youth. After looking on the GSU Web site, I came across the work of my dissertation chair, Dr. Kirk Elifson. I was drawn to his work because I was familiar with the geographical location. I had no formal training in HIV/AIDS research or drug abuse, nor did I have formal fieldwork training. I simply wanted to work on an applied research project. I e-mailed him explaining my desire to learn more about his project. He responded and suggested that I meet with him and the co-primary investigator, Dr. Claire Sterk, who also was one of my dissertation committee members. After that meeting, I visited the HIP House and met the project director and other staff members. The project director asked me why I wanted to work there. I responded naively, “because I want to help these women.”

I say naively, because my agenda was to get as many of them to drug treatment as I could. I wanted to touch and change lives. I had no idea what the research project entailed and that my personal agenda—if carried out—would actually have been in conflict with the study design. But, that didn’t stop me in the early months of the study. In fact, my personal goals resulted in the entire staff having to go through a day of retraining where the interventionists voiced their frustrations with my approach to “preaching” to the

women about drug treatment prior to their intervention. The primary investigators agreed to allow me to continue working there and I agreed to not speak of treatment until after a woman had completed her six-month follow-up. However, as an interventionist, I could assist my own clients within the guidelines of the research project. This consisted mainly of waiting until the women initiated a discussion about drug treatment.

At this point I had no particular theoretical framework for my dissertation project. I was taking a class on grounded theory and had worked with secondary text to build theory. I now wanted to conduct a research project in which I used my own interviews to build theory. After discussing my goals and interests with the primary investigators, I was assigned the task of conducting qualitative interviews for understanding the women's perceptions of the risk reduction process. We agreed on an interview guide that would serve a dual purpose: (1) investigate the intervention process from the women's perspective and (2) serve as a first step in learning more about how these women cope with multiple oppressions.

In-Depth Interviews

The in-depth interview was used to understand how at-risk women make sense of their lives and behavior within the context of risk reduction and an at-risk environment. Additionally, I was able to inquire about behaviors, people, and places I observed in the Rough. Each woman was given a brief overview of the qualitative interview process. I began by introducing myself, followed by informing women they had been selected to provide more details about their risk behavior and life in general. I gave some details about my background as a product of the inner city and tried to present myself as someone genuinely interested in helping women in the neighborhood. In some cases I talked about the fact that I had never personally done or been addicted to drugs, yet my family had been greatly impacted by the crack cocaine epidemic. In other situations, the women asked me questions about my life. Still other women interjected and started the interviews by recalling some interaction they had with me earlier. Those who had been my clients typically updated me on their areas of progress as well as setbacks. There were a few whose family and children I had met over the course of the intervention and I was sure to ask about them.

The interview guide served as a key tool for the in-depth interviews. I used it as a guide only with the understanding that not every question was relevant to each woman. To be clear, I had memorized many of the questions from the interview guide by about the twenty-fifth (of forty-five) interviews and was able to focus on the participant as opposed to "my questions." In fact, in the last eight interviews, I did not use the interview guide to collect data. I asked the women to talk about themselves and the interview flowed from wherever their conversations began (Gentry, Elifson, and Sterk, 2005).

I informed each woman that she would be compensated fifteen dollars for her time and could request to end the interview or make statements off the record at any time. Interviews lasted between forty-five minutes and two hours. The average length was approximately one hour. The process began with a verbal reiteration of the informed consent, as each woman had previously signed a consent form at the beginning of the study. While this form included the women's consent for every phase of the study, I discussed the key differences between this interview and the others to ensure that they knew they were being taped. All forty-five interviews were tape recorded and transcribed verbatim. The use of the tape recorder was discussed with each participant at the beginning of the interview. While they were encouraged to view the machine as an aide, they were given the option of refusing to be taped. Throughout most of the interviews, the respondents periodically glanced at the recorder, particularly when discussing participation in illegal and other high-risk activities. This may be due in part to the emphasis I placed on being willing to allow them to talk "off record" about sensitive issues. I was careful to balance giving enough information to make each woman feel comfortable talking to an outsider about her private life, while keeping questions brief enough to avoid prompting for a particular response. For example, I did not want the women to feel that I was searching for answers that they were drug free and in monogamous relationships (Gentry, Elifson, and Sterk, 2005).

Generally, after an hour clear patterns emerged concerning particular lifestyles. As suggested by Berg (2001), social life operates within fairly regular patterns that allow for the general classification of things, persons, and events. For the women in this study, those "emerging patterns" centered on the day-to-day life on and off the streets, sex work, intimate partners, housing arrangements, family backgrounds and upbringings, HIV risk factors, and drug use (Gentry, Elifson, and Sterk, 2005).

In some cases, I would like to have continued probing on areas of interest, but interviewing drug users can be challenging. Some participants were fatigued from their prior night's activity. One participant showed up immediately after having engaged in excessive substance use. After attempting to talk with her for a few minutes, we both agreed that she should be rescheduled. She returned the next day and completed a one-hour interview (Gentry, Elifson, and Sterk, 2005).

Some elected to speak off record, mainly about criminal activity, welfare issues, rape, and the ways in which they lost their children. I honored these requests every time. For that reason, five of the transcribed interviews were much shorter than the others, yet I have additional notes concerning the off-record conversations. This resulted in ten typed pages of notes—approximately two pages per off-the-record interview (Gentry, Elifson, and Sterk, 2005).

The interviews were conducted in the same setting as the intervention sessions. Upon arriving in the room for their interviews, several women commented on remembering their sessions having been in the same room. They immediately began to recall certain things that were important to them at the interview

site. This assisted in establishing trust and rapport, as well as helping women recollect their experiences because they were familiar and comfortable with their surroundings (Gentry, Elifson, and Sterk, 2005).

HIV Testing Post intervention

The last thirty-three participants were asked to retake the HIV test. Two did not retest because they tested positive the first time. The first ten were not retested because it occurred to me after analyzing the first few interviews that these women were still displaying risky behavior to varying degrees and for a variety of reasons. Therefore, I asked the primary investigators to approve an HIV retest for the remaining qualitative interview participants. All of the retests were negative. I retested twenty-one of the thirty-three women, and an outreach worker assisted with the other twelve. For those I tested, I turned on the tape recorder during the HIV test to capture our conversations about the test and about AIDS in general. None of the thirty-three women were reluctant to take the test. Some began to open up during this process about times they put themselves at risk; others were adamant about not having put themselves at risk and appeared almost proud to retest and “prove” to me that they were practicing safer sex. All of the women expressed a desire to know their results, and with the help of an outreach worker, I made an effort to re-contact them. However, not all women were accessible, despite having provided clear directions on where to find them. I personally delivered eight test results; and other outreach workers assisted in delivering to seventeen women their test results. Eight women of the thirty-three did not receive their results.

THEORETICAL FRAMEWORK

Black Feminist Thought

I selected black feminist thought as a critical theory for interpreting the women’s lives in a way that clarifies a standpoint for poor African-American women in relation to the social, political, and economic issues that may impact their risk for HIV/AIDS (Collins, 2000). One of the key tenets of black feminism is its indictment of institutional practices. The unequal relationships that these practices represent are what Collins (2000) implies are legitimate issues for black feminist theory to analyze and ultimately act upon. Black feminist thought as critical theory works to question the legitimacy of those social institutions that exploit black women or any other oppressed groups in our society. Existing and past institutional practices that place poor black women at risk for HIV/AIDS in high-risk environments fit

black feminist criteria for social problems that should be addressed theoretically and practically (Gentry, Elifson, and Sterk, 2005).

Collins (1998) defines critical social theory as encompassing bodies of knowledge and sets of institutional practices that actively grapple with the central questions facing groups of people differently placed in specific political, social, and historic contexts characterized by injustice. Accordingly, critical theory is generally used to critique the ways in which people are constrained to act and to identify themselves in terms of particular social institutions. In *Black Feminist Thought*, Collins (2000) outlines a discourse for interpreting the experiences of African-American women by integrating the key works of several leading black feminist authors. Her thematic approach can be applied to understanding poor African-American women's lives in relation to HIV/AIDS intervention.

The first theme is that of self-definition and self-valuation. Collins (2000) conceptualized self-definition as "the idea of challenging the political knowledge-validation process that has resulted in externally defined, stereotypical images of African American women and black womanhood." The second theme centers on black feminist thought as a sociological perspective that interconnects race, class, and gender as being equally oppressive in our society. The third theme is that a black feminist perspective is necessary in understanding the unique experiences of African-American women. The strength of this theme is its insistence that even women who practice so-called deviant behavior have a voice in black feminism. The fourth theme centers on the controlling images constructed for poor African-American women. The image of the "crack whore" emerged as a class-specific, controlling image placed on poor African-American women who trade sex for crack and money. Finally, black feminist thought provides a framework for examining structure and agency as a platform for social change. A structural argument shows the historical legacy of interlocking oppressions, focusing primarily on how, within hierarchical power relations, the ideas produced by elite groups about community, difference, voice, and justice are the ruling ideas. This fifth theme reflects a point of synergy between the experiences of African-American women and others that are at risk for HIV infection primarily due to social inequality.

Symbolic Interactionism

Symbolic interactionism is a theoretical perspective for understanding the processes, interactions, meanings, and interpretations of various social phenomena (Blumer, 1969). Specifically, it is concerned with what common set of symbols and understandings have emerged to give meaning to people's interactions (Patton, 1990). In addition, it provides guiding principles of qualitative inquiry for scholars who want to research and interpret human group life and human behavior. In *Symbolic Interactionism: Perspective and Method*, Blumer (1969) acknowledges that several leading scholars contributed to the

intellectual foundation of symbolic interactionism, including Mead (1934), Thomas (1972), James (1890), and Cooley (1902).

Blumer (1969) conceptualizes the nature of symbolic interactionism as centered on three premises, including meanings, social interactions, and interpretations. All of these concepts are relevant in the process of reducing risk among a specific group of people. First, he argued that human beings act toward things on the basis of the meanings things have for them. Second, Blumer (1969) offers that meanings are social products that are formed through interaction with other people. Third, Blumer posits that meanings and interactions among individuals undergo an interpretative process, in which each person deals in varying degrees with things encountered in everyday life. Blumer further offered that interpretation should not be regarded as a mere automatic application of established meanings. He perceived interpretation as a formative process in which meanings are used and revised as instruments for the guidance and formation of action.

Symbolic interactionism offers an explanation for how individuals interpret and select for themselves the “slices” of behavioral change they will attempt generally based on their daily reality. In this case, the process of “slicing” behavioral change strategies is influenced by one’s self-perceived reality as a poor African-American woman who smokes crack.

At the root of symbolic interaction is a desire to understand aspects of human groups and the ways in which these women go about life’s activities (Blumer, 1969). In this way, symbolic interaction shares common theoretical premises with black feminist thought. Implicit in symbolic interactionism is the notion that one wants to understand a group’s culture, including customs, traditions, norms, values, and rules. Additionally, scholars of symbolic interactionism want to understand the impact of social structure—that is, the relationships derived from how people act toward each other based on social position, status, role, authority, and prestige—on a particular group of humans (LaRossa and Reitzes, 1994; Maines, 1989; Stryker, 1980).

Social Constructionist Perspective

The social constructionist perspective provides a theoretical framework for examining the objective and subjective realities of everyday life. In examining the social construction of high-risk environments, where risky drug and sexual behavior is objectified as the norm, researchers are able to explain the social context within which the HIV risk reduction intervention takes place. Berger and Luckmann (1966), who clarified a sociology of knowledge in their book, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, argued that “the basic premise of reality as socially constructed is that truth and knowledge are discovered, made known, reinforced, and changed by members of society. As social

beings, we respond to our interpretations and definitions of situations, not the situation themselves, thereby shaping reality.”

Thus, prevention intervention program implementers must attempt to make some sense of the realities that shape the lives of the target population in order to be effective in getting high-risk participants to change their behavior. Likewise, the targeted population is trying to interpret the key points of risk reduction for themselves and in doing so shape their own reality about their risky behavior and their prospects for change. So, as those who practice high-risk behavior discover their own risk factors, they either defend their reality or attempt to change their reality.

Berger and Luckmann’s theory of the social construction of reality is divided into three key components, each having relevance for the social construction of high-risk environments and high-risk behaviors. First, they discuss the foundation of knowledge in everyday life. Next, they examine society as objective reality in terms of how reality becomes institutionalized and legitimized over time and in space. Finally, they posit that society as subjective reality centers on the internalization of reality in primary and secondary socialization.

An understanding of everyday life as internal and external reality provides theoretical overlap between symbolic interactionism and social constructionism. A perspective of one’s “total reality” is applicable to the case of crack-using women, as it highlights that the meaning of crack cocaine is internal for those who use the substance, and yet there is an external, albeit stigmatized reality of crack usage among those who do not use this drug. Berger and Luckmann lay the foundation for the social construction of reality by theorizing about the reality of everyday life. They perceive the reality of everyday life as an ordered reality. The authors build on this in the following quotation:

Its [the reality of everyday life] phenomena are prearranged in patterns that seem to be independent of my apprehension of them and that impose themselves upon the latter. The reality of everyday life appears already objectified, that is constituted by an order of objects that have been designated as objects before my appearance on the scene. The language used in everyday life continuously provides me with the necessary objectifications and posits the order within which these make sense and within which everyday life has meaning for me. I live in place that is geographically designated; I employ tools . . . I live with a web of human relationships . . . which are also ordered by means of vocabulary. In this manner language marks the co-ordinates of my life in society and fills that life with meaningful objects. (1996, p. 21)

What Berger and Luckmann offer is that everyday life is organized around various social interactions and the language used to transmit meanings. Social interaction in everyday life has a profound impact on the process of risk reduction. It is tied to the key component of everyday life as structured both spatially and temporally. Time of day and place of risk, as well as time of day and place of intervention, are

important elements of how people in high-risk environments create reality and respond to behavioral change.

In addition, spatial structure is a key component to the social construction of high-risk environments. If these women smoke crack in their own homes, they may have different experiences with risky behavior than those women who are forced or choose to smoke and trade sex in crack houses. Likewise, those who smoke outside on the streets may avoid some risk factors such as getting stuck in an unsafe crack house.

High-risk environments where individuals smoke crack and trade sex have a language and knowledge that is associated with everyday life for members of this group. Berger and Luckmann refer to this as “the common stock of knowledge.” In the case of high-risk environments, common stock of knowledge includes what people believe about HIV/AIDS, what people believe about the risk of drug use and sexual behavior in relations to HIV/AIDS, and what people believe about their chances of getting HIV/AIDS.

Summary of Theoretical Perspectives

The three theoretical frameworks presented in this chapter explain key aspects of the relationship between poor African-American women who use crack and the social structure within which they experience everyday life. Each theoretical framework that offers micro sociological analysis of a particular social phenomenon should also include a perspective on the macro sociological structures within which a person experiences everyday life.

In addition, each theory provides a perspective of self, which has implications for HIV intervention in the lives of the socially constructed poor African-American crack user. All three theories presented focus on some aspect of these individuals as capable of developing a capacity for thinking, defining, and self-reflecting. Each theoretical framework acknowledges to varying degrees that individuals shape their environments through their actions and reactions. Moreover, these women can radically alter their definitions of self and situations, and in doing so they can change their high-risk behavior. The specific focus of self for each theoretical framework includes symbolic interactionism’s ideas about self-development, social constructionism’s emphasis on the construction of an internal and external self, and black feminism’s highlighting of the importance of self-definition and self-valuation.

Together these three theoretical frameworks offer a comprehensive perspective of how poor African-American women who use crack cocaine interact with others in high-risk environments. To be clear, each theoretical perspective has a different slant on the degree to which the interactions are actively constructed. Black feminist thought stands apart from the other theories because of its more radical discourse and synergy with other conflict perspectives. However, black feminism’s core themes of self-definition and self-valuation provide a natural alliance with the other two theories.

In addition, these theories provide a framework for analyzing high-risk environments as social structures with a particular social order. Again, black feminism tends to focus more than the other theories on the powerful social forces as “shapers and maintainers” of the high-risk environments. As such, black feminism supports a school of thought that poor African-American women unconsciously relinquish their internal power to these external forces. Only by defining and placing a value on the self are African-American women able to reject objectified roles and replace them with more authentic ones.

While the other two theories focus on change through redefining situations, their general inclination to do so void of race, class, and gender sets them apart from black feminist thought. Also, black feminist thought views social institutions as more structurally situated than do the other theories presented in this chapter. Black feminism advocates that these social organizations do not change as a part of the natural order of society, but rather they must be changed via external pressure from those experiencing social inequality as a part of everyday life. In any case, all three perspectives have direct implications for attempting to change high-risk behavior in high-risk environments.

Each theory supports an ethnographic inquiry for exploring processes and meanings among individuals and social forces that help shape their lives. Symbolic interactionism focuses on interpreting the meanings, interactions, and processes associated with HIV prevention programs. The social constructionist perspective highlights how high-risk environments have an objective and subjective reality, along with the people and behaviors that are associated with such environments. Finally, black feminist thought clarifies key components of the first two theoretical frameworks from the standpoint of African-American women.

RESEARCH OBJECTIVES

The overall objective of this study was to gain an understanding of how poor African-American women who smoke crack cocaine reduce their risk for HIV infection. Several research questions guided the inquiry for accomplishing this objective: (1) What conditions and behaviors led to these women being labeled at risk for HIV/AIDS? (2) How do they interact in their present environment? (3) What strategies do they use to cope with being at risk for HIV/AIDS? and (4) What are the consequences of their participation in an HIV/AIDS prevention intervention?

The first question seeks to explore how these women came to be at risk for HIV/AIDS. Their perception of why and how they are at risk provides valuable information to HIV/AIDS prevention planners. The second question focuses on understanding their everyday lives as high-risk women living in a high-risk environment among other high-risk actors. The third question suggests that women are coping with their present situation, albeit on the margin, and that these coping skills can be enhanced to help women reduce their high-risk behavior. The fourth question implies that these women have agency and

perceive themselves to be empowered to make changes in their behavior that may result in decreasing their risk for HIV infection. Together these questions are key in constructing implications for HIV prevention programs for poor African-American women who smoke crack.

Given the continued increase in the number of new cases of poor African-American women who use crack cocaine, we know that a simple transfer of risk reduction strategies is not the most effective method for reversing the trend among this high-risk group. For the most part, public health scholars and practitioners have ignored African-American women's unique history when designing and implementing risk reduction. A careful examination and appreciation for African-American women's socialization in the United States would provide historical evidence as to how they survive and strategize despite pressure from oppressive forces (Gray-White, 1999; White, 1994). In essence, authentic voices of black women's risk and resilience are very much needed in HIV prevention.

CHAPTER 9

Black Feminist Theory As Behavioral Change Theory and Practice

Ain't no control. Whatever y'all do ain't nothing gone change. It's gone take a hell of a lot to get a person off drugs. They got to come with some kind of cure, some kind of medicine. But just talking and trying do this and that for them, that ain't lasting.

Theresa, a 37-year-old HIV-positive crack cocaine user and seller, sex worker, and mother of five

Throughout this book, I discussed principles to guide the next generation of HIV prevention initiatives as gender and culturally appropriate high-risk women. These principles are guided by the reality that conditions that lead to black women's risk for HIV are different from other high-risk groups. Moreover, the barriers and facilitators that impact one's ability and willingness to (1) acknowledge and (2) change high-risk behavior are different for black women along a continuum of high-risk factors and circumstances. Despite these differences, HIV prevention strategies continue to support traditional risk reduction techniques that have proved effective in lowering risks among other high-risk groups (Fisher and Fisher, 2000). As the women suggest, their lives are more complex as they grapple with intersecting oppressions and limited choices that are part and parcel of their risk for HIV. In this final chapter, I present a case for using the core principles of black feminism as key elements of an applied HIV prevention program targeting high-risk women.

I began this behavior research with the idea that a deeper understanding of the women's everyday lives and decision-making process would help me understand the core elements of the next generation of HIV prevention programs aimed at high-risk African-American women. At the end of this undertaking, I realize that in order to change lives you must change minds; and in order to change lives, you must change hearts; and in order to change hearts, you must understand history. In this way, I am inclined to agree with Theresa, who in the opening quote is very pessimistic about the future of HIV prevention programs' current capacity to help black women change over longer-periods of time. As she articulates in her own voice, long-term change must take on a new commitment to engage high-risk women on a deeper level. For high-risk black women, I am adamant that any attempt to plan and implement HIV prevention programs not grounded in black feminist perspective will be limited in its approach and scope. At the same time, I challenge black feminists to become more public health research and practice. This is the only way black feminist theory will be viewed as a legitimate framework for change in public health. It is our responsibility to provide a methodology for how black feminist themes can shape public health programs in general, and HIV prevention programs in particular. In this chapter, I apply black feminist

themes as the core elements of an HIV prevention program based on the ethnographic findings from this study. A black feminist perspective allows these women to speak about their everyday experiences in order to discover aspects of changing risky behavior that currently are not included as part of traditional risk reduction programs.

Poor African-American women who use drugs see HIV as part of a larger problem impacting them and the Rough as a disintegrating community. Collins (1990) has conceptualized these “bigger issues” as a matrix of domination, referring to the overall organization within which intersecting oppressions originate, develop, and are controlled. She further deconstructs the matrix of domination into four parts. First, structurally, there are laws that allow injustice to permeate our entire society. For these women, the most relevant are our laws concerning welfare, drugs, and housing in America. Second, the implementation of the laws and policies ensure the transformation of racism and sexism from one generation to another. Next, the hegemonic nature of the social organizations in our society justifies the continued unequal practices of bureaucracies, which leaves marginalized groups depoliticized. Finally, as the women in this study have confirmed, the matrix of domination has a component that absorbs these women interpersonally, as they experience on a daily basis the unequal practices of our major social institutions, including the U.S. legal system, labor markets, schools, the housing industry, and social services. Given the list of “other” killers in impoverished urban areas, keeping a roof over one’s head is often a more pressing priority than the threat of HIV. Moreover, the women in this study suggest that the motivation for their changed behavior is less influenced by individual reasons and is more related to concerns for family or significant others.

A key implication for HIV prevention intervention programs is the role of referrals in linking these marginalized women with to outside the Rough. The women who made longer commitments to change had help in leaving the Rough via connections to social services that assist at-risk citizens. Those who returned to the Rough were highly likely to revert to the old unsafe practices, while those who remained in residential drug treatment programs or community-based drug ministries, and relocated to more socially integrated communities, were able to continue safe behavior practices. Moreover, gaining access to safe and affordable housing begins to address some of the larger structural issues that place these women at risk in the first place (Woods, 1998).

By incorporating key components of black feminist theory into existing HIV preventions, planners can take a closer look at what works in the lives of poor African-American women who smoke crack when designing more effective programs. One of the key contributions that black feminist scholars have made in sociology is to challenge dualistic thinking. In the case of behavioral change, traditional measures have been “either/or” conclusions. For example, conventional scientific standards for measuring program success limit researchers to conclude that either a woman changed her risk behavior or she did

not. Perhaps, black feminists' most radical premise has been their rejection not only of what is concluded about black women, "but the credibility and the intentions of those possessing the power to define" (Collins, 1991a). According to Collins (Collins, 1991a), when black women define themselves, they clearly reject the taken-for-granted assumption that those in positions granting them the authority to describe and analyze reality are entitled to do so.

Black feminist perspective argues that the "other changes" defined as important by the women should be moved from the margins to the center of prevention intervention for the simple reason the women themselves focused on them as self-defined successful outcomes (hooks, 1984). Because the women declared them as central to their lives, I argue that they should be the basis for building programs that are effective in the lives of at-risk women (Scott, Gilliam, and Braxton, 2005; Ward, 1993; King, 1988).

Traditional risk reduction methods are more effective in the lives of people who have race, class, and gender privilege in our society (Auerback and Coates, 2000). For these women, a greater emphasis was placed on basic survival needs, such as eating on a regular basis, getting steady employment, and securing safe, affordable housing. Once the women saw improvement in their daily lives, they made even greater commitments to increase condom use and decrease drug use. Moreover, the women who made permanent changes were those who were able to change environments—even if temporary—as opposed to changing within the environment (Geronimus, 2000).

Black feminists have consistently maintained that African-American women have agency, and they often use this argument to empower African-American women to act up for a change under current oppressive conditions (Guy-Sheftall, 1995). hooks (1981) argues that mainstream feminism has never emerged from the women who are most victimized by the various oppressions and are powerless to change their condition in life. Thus, black feminism provides a platform for empowerment that includes the voices and perspectives of crack users who are at risk for HIV in high-risk environments.

A greater appreciation for the past and present plight of African American women will help prevention specialists develop better individualized plans. For example, interventionists need to consider that homeless women who have been deprived of socioeconomic resources may react differently to receiving HIV-positive results than would middle-class persons who have a higher stake in society. Both groups of women may be initially shocked, hurt, angry, or scared of the meaning of an HIV-positive status. Because of the evolving meaning of HIV due to medical breakthroughs, a homeless woman may internalize the meaning of HIV as a way of gaining access to social services she was previously denied. In addition, the meaning of HIV has shifted from a discourse of "dying from AIDS" to "living with HIV," as one can realistically live for an estimated ten to twenty years with HIV, depending on other medical and socioeconomic factors. However, the meaning of HIV among the middle class and the truly disadvantaged over time will differ greatly: One may view it as a loss of privileges, whereas the other can

point to some gains in housing, drug treatment, mental health counseling, job search assistance, and access to health care.

HIV prevention intervention planners also need to understand that the meaning of crack cocaine in the lives of high-risk women is totally different than what outsiders might expect (Sterk and Elifson, 1993). For example, in addition to just wanting to get high, poor crack users may view crack as a stress or pain reliever, as many have limited and stigmatized professional counseling, preventive medicine, and health insurance. Thus, risk reduction strategies that attempt to convince crack users of the harmful effects of the drug may not be as successful in practice because of the positive meanings and benefits the crack user perceives she derives from the drug. Therefore, interventions that include sessions about the potential harm of crack cocaine must take into consideration the meaning this drug has taken on among users at various stages in their drug-using career.

In terms of behavioral change via risk reduction, poor African-American women interpret and select for themselves the “slices” of change they will attempt generally based on their daily reality. These “slices” are highly dependent on women’s perception of changes they can make within their current environment. Once these women attempt risk reduction, in whatever form, they are likely to suspend actions that are not working, and to rethink and retry those goals they really want to achieve. Moreover, over time they are likely to transform their thinking about risk and risk reduction in light of each interaction in which they are placed at risk and primarily direct their actions based on their unique interpretative process. In this case, the process is influenced by their self-perceived reality of being poor African-American women who smoke crack.

HIV prevention specialists need to understand how poor crack-using African-American women can be both victims and villains in a high-risk environment. Hence, depending on the situation at any given time, they may be “tricked” or they may “trick” others with whom they interact. For example, women who trade sex for crack or money may begin their day with condoms, some money, and drugs left over from the previous day. If they have these resources, they are in control of the interactions that take place with potential customers.

If women are not desperate at the beginning of the day, or whenever they decide to take to the street, they may even be inclined to turn down sex work that appears risky. This includes someone wanting anal sex, wanting to take them out of the neighborhood, or not wanting to use a condom. They express verbal and nonverbal signs that they are not desperate at this time, and those they encounter will respond to their demonstrations of control. They are also keen at gleaning clues from the conduct, appearance, and attitude of potential customers, some of whom they may know from previous encounters are attempting to get sex without paying. Thus, if they are presenting themselves as sex workers and deliberately hiding the fact that they smoke crack, they may be able to maintain control of the situation.

However, if it is a customer who has known them in the past, he may become frustrated with their appearance of control, as he knows they smoke crack and often perform risky acts for money and drugs. The potential sex customer's patience wears thin when he is not able to get them to act in his favor if he knows that the women are members of the stigmatized crack-smoking sex workers. This may prompt him to walk away from the negotiation in search for a woman who is willing to meet his price and perform his preferred sex act. Thus, sometimes even if these women are not desperate for money or crack, they may change their presentation of "safe self" to maintain clientele.

Some of these women attempt to deceive newcomers to the drug and sex trade out of money and drugs. They do this by taking the newcomer's money and promising to go deeper into the high-risk environment and bring them back the best drugs. Newcomers and non-African Americans come to the edge of the high-risk environment, but remain at the mercy of those who act as go-betweens for the drug dealers. If the women believe the people will not remember them or attempt to find them later, they may never return to give the newcomers their drugs or money.

However, as the day goes on, some crack-using women find themselves having smoked their drugs, spent their money, and now in need of more resources to get through the night. Thus, they shift from a position of self-control to one of vulnerability. Once others in the environment—potential Johns and drug dealers in particular—assess them to be desperate and weakened, they may approach them to perform again the very risky acts the women confidently declined earlier. It could be the same people making the request or another group of men whose own meager resources only allows them to approach those who are willing to sell sex cheaper than women who may not be using drugs. Thus, crack-using women who present themselves as practicing safe sex may do so during certain times of day. However, a more careful analysis of their full range of activities during the day, week, and month may reveal a self that takes risks at certain times and under certain conditions.

In addition, because of the stigma attached to crack cocaine, even among drug users, many crack users seek to differentiate themselves from the "generalized other" crack smokers. Most crack-using women attempt to avoid such labels applied to crack users in general (crackhead) and crack-using women in particular (crack whore). Some, however, become immune to what others think of them over time and may not react in a way that leads to changes in risky behavior. In essence, they display a presentation of self that makes it harder to implement risk reduction because they put on defensive fronts about their risky behavior. HIV/AIDS interventionists must understand how various social interactions in the everyday lives of crack users may impact behavioral change. These social interactions generally are based on unequal social positions between crack-using women and more powerful drug dealers and sex solicitors in particular.

Drug-using women pass through distinct stages of socialization that draw them deeper into the socially stigmatized crack subculture and may result in more encounters in the high-risk environment that heightens their risk for HIV. For example, a woman who smokes crack is not at a high risk for HIV simply because she smokes crack. Her risk is heightened as she moves through various stages of drug use and at some point may find herself trading sex for money or crack.

First, poor African-American women who eventually go on to smoke crack begin as a potential crack user observing others in the high-risk environment in different roles and carrying out different responsibilities. At this stage the woman may not be a crack user herself. She may drink or smoke marijuana but has not graduated to the stigmatized crack cocaine. As she uses these other “gateway” drugs, she is able to observe the crack culture because she most likely is smoking marijuana and drinking alcohol in the same high-risk environment. Yet she has not crossed the line to learn how to use the tools for smoking crack. Generally, someone offers it to her. She may refuse on the first offer, as she cannot see herself taking part in the crack subculture. However, every crack user obviously has that initial socialization moment where she is invited or elects to try crack for the first time.

No matter the initiation process, once she has smoked crack cocaine a few times, within the crack subculture, she moves from the observation stage and into the participation stage, where she has taken on a particular role as a crack user. As a newcomer to the crack culture, she may not know all the different roles and rules. She may find herself getting cheated out of money and drugs by more experienced users and dealers who exploit her status as newcomer. As she interacts more with others in the crack-using scene, she becomes familiar with more of the roles and responsibilities associated with everyday living as a crack user. So, as a particular woman increases her interaction with drug users, drug dealers, and women who trade sex, she may find herself taking on some aspects of these roles in the play stage. If she interacts more with drug dealers, she may attempt to sell drugs for someone rather than become a sex worker to supply her habit. In any case, during this second stage, a drug user begins to distinguish between a number of social roles in the high-risk environment and spends time actively playing a role or roles. To be clear, she is probably gravitating toward a particular role that best meets her personality and other character traits.

Finally, crack users enter a third stage where they learn more about the elaborate rules and roles of the drug culture. Poor African-American women who advance to this stage may be harder to reach with HIV prevention messages because they are so engrossed in the crack scene. For the drug culture, this stage is synonymous with the internalization of the values and expectations of the larger society and the complex interrelationships between roles. When drug users enter this stage, much of their daily activity is governed by high-risk rules of behavior. As such, a crack user not only learns her role, but also the roles of every other player and their relationships to one another in particular situations. To paraphrase Mead (1934) in

Mind, Self, and Society, each individual's action is determined to some extent by what she assumes other players' actions will be.

HIV risk reduction programs that target crack users must be mindful of where the at-risk person stands in the stages of socialization into the drug culture. If she is in the early stage and perhaps still has some ties to mainstream society, the intervention will have a different impact than if she has been using crack for ten or more years. For example, crack-using women who have maintained the role of "mother," "employee," or "caregiver" may have a more positive and immediate change of behavior compared to women who have little to no social support network outside the drug-using community.

There are at least two distinct extremes of reaction to HIV intervention for long-term crack users. Some may view it as a defining moment that helped them make the decision to make some positive behavioral changes. Others, however, may not attempt to make changes because they perceive those with whom they interact in the drug culture as key to their survival. In addition, one is more likely to adhere to risk reduction principles if she is at a point where it is becoming more painful and difficult to maintain the role of crack user.

RETHINKING THE HIP INTERVENTION

The HIP intervention was developed and implemented based on gender and power theory. In planning for the next generation of HIV prevention for high risk black women, we need to advance the theoretical paradigm to include key tenets of black feminism. In this section I discuss some practical ways to build upon the HIP intervention in ways that can be applied to other existing women-centered HIV programs grounded in gender and power theory. Collins (2000) asserts that black feminist thought is a black woman's interpretation and explanation of social phenomenon based on the idea that we think differently about social issues. In addition, we ask different questions about the nature and solutions of social problems in comparison to our white and male counterparts. While this thought process is meant to reflect an insider's standpoint, it is by no means critical of the HIP intervention, as the women themselves have validated the effectiveness of the process by which the HIP intervention reduced their risk for HIV. I suspect they found it to be effective because it was grounded in general feminist perspectives, and thus has some commonalities with black feminism. To demonstrate this, in Table 9.1 I highlight how the five themes commonly discussed in a black feminist perspective were addressed in the HIP project. In addition, I show how black feminism is different in scope in comparison to general feminist approaches to action research. As these observations arise from the women in this study, they represent what Lorde (1996) calls an "authentic black feminist standpoint" because the perspectives are from those experiencing the problems first hand.

TABLE 9.1. A COMPARISON OF THE HIP INTERVENTION AND BLACK FEMINIST PERSPECTIVE

THEME	HIP INTERVENTION	BLACK FEMINIST PERSPECTIVE	IMPLICATIONS FOR FUTURE INTERVENTIONS
<i>Self-definition and self-valuation</i>	Influenced by “either/or” perspectives seeking to quantify change, and is generally based on existing indicators for changed behavior	Influenced by the idea that black women judge their behavior by comparing themselves to black women facing similar situations, with change generally seen as relative to others in their environment	Develop a formal role for successful program graduates to serve as peer leaders, with a greater emphasis on culturally and gender appropriate indicators of change
<i>Race, class, and gender</i>	Emphasis on poor women with race underexplored	Emphasis on black women with class underexplored	Place more emphasis on understanding the social construction of race, class, and gender in each woman’s life
<i>Unique (historical experiences)</i>	Focuses on oppression, consciousness, and action centered on the motto “The personal is political”	Historical oppression, hidden consciousness, collective action centered on the motto “Lift as we climb”	Formal programmatic ties to black churches and women civic organizations and train women as “sister advocates”
<i>Controlling images</i>	Replaces crackhead and crack whore images with a nonjudgmental tone toward women as sex worker and drug user	Replaces crackhead and crack whore images with positive roles for black women as mother, worker, caretaker, wife, volunteer, daughter	Develop a formal method for assisting women with reunification with family of origin and procreation, as well as job training, parenting skills, relationship counseling, and volunteer opportunities
<i>Structure and agency</i>	A greater emphasis on agency “Here is a list of services and agencies. Let me know how it goes”	A greater balance between structure constraints and self-empowerment “Here’s an advocate who will help you access services and navigate through the intensity and politics associated with assessment and in-take processes for community-based programs	Formally train community-based organizations as mentors/advocates that increase links to services

In examining the theme of self-definition, the HIP project used quantitative methods to determine if women changed their risky behavior. Black feminism questions “either/or thinking” because it forces black women to choose between extremes when their true experiences might fall along a continuum. In addition, a black feminist perspective acknowledges that black women define their success or failure based on other black women facing the same situation as being the norm. In this case, then, the HIP project could have enhanced its effectiveness among black women by using successful program graduates

as peer leaders and find a formal role for them in the prevention intervention program. Perhaps, such an approach would have been beneficial for the “hard to reach and retain.”

Next, in terms of intersecting oppressions, the HIP project related to the women’s class and gender status—as poor women—and may have left race somewhat underexplored. At the same time, one of the weaknesses of black feminism is that it speaks of including all women but tends to privilege black middle and upper-class women. Thus, a future program would be effective in formalizing a process by which the women could provide richer details on how they grapple with the intersection of race, class, and gender.

In addressing the women’s unique experiences, the HIP model was geared more toward the feminist motto “the personal is political,” implying a greater emphasis on self-empowerment in order to change one’s circumstances. The historical motto of black women has been “lift as we climb,” indicating that as a sisterhood fighting multiple oppressions, black women must model the change behaviour they seek in others. The practical enhancement for the HIP model would be formal group discussions with women who are tied to the church and community, where this motto originated. As the sessions at the HIP House were individual in nature, it may have left an historically effective change process for black women underutilized. My recommendation of formal group discussions is not to be confused with group discussion limited to women who use drugs.

Specifically, the women expressed needing help with housing, escaping domestic violence, regaining custody of or visitation with children, and other legal issues generally associated with drug law violations. Others wanted social support while in drug treatment, help with job hunting, and transportation to various community-based resources. Another group expressed a desire to have help in establishing communication with their extended family and children. These are all ways in which non-drug-using women committed to “lift as they climb” could help enhance interventions for the socially isolated.

I believe the HIP intervention was quite effective in helping women have dignity even on the margins. I saw women walk into intervention rooms with lowered heads and tearful eyes. Many would walk out an hour later with a smile and chin up. I believe this was due to the way each interventionist facilitated discussions about the women’s roles as drug users and sex workers in a non-condemning environment. However, as the process interviews revealed, the women would like to have talked more about themselves in other roles, as mentioned in Table 9.1 whether present or past. A black feminist perspective challenges the women to set goals based on the roles and images they would like to have in the future. As many women expressed wanting a better relationship with their mothers and children in particular, another enhancement would be a formal role for the women’s biological family in risk reduction. Again, this thought stems from the historical role that black mothers have played in their children’s lives.

Finally, the theme of structure and agency was present in the HIP intervention. For example, if a woman received an enhanced session, then her interventionist could help her access community and social services. I argue that the intervention placed more emphasis on agency, as interventionists often provided a list of services and had no formal system for assisting women. To be clear, many interventionists maintained contact with some women well beyond their ties to the HIP intervention. However, a black feminist approach would recognize that women on the margins need systematic help in navigating through the politics associated with getting social resources. As such, advocacy should take on a more formal role in HIV intervention.

The significance of black feminist thought in HIV prevention intervention is its acknowledgement that African-American women have agency, and even in dire poverty, a sense of empowerment to think and act toward changing their own oppressive situations (Taylor, 1998). The women in this study have defined themselves as capable of making long-term changes if they have the right environment and mindset. As these women articulated their struggles within the context of their living arrangements, the solutions to their problems should take into account improved housing. I have attempted to outline what a black feminist approach to intervention might look like in the lives of African-American women at risk as grounded in the five major themes Collins argues represents black feminist perspective. Clearly, my suggestions are meant to enhance the effectiveness of the HIP intervention as a way to capture those women (1) who did not make changes in their sex or drug-using behaviors; (2) who made short-term changes and reverted back to risk behavior in three months or less; and (3) who were ready to make changes just as their HIP intervention was ending.

AN HIV PREVENTION MODEL FOR BLACK WOMEN GUIDED BY BLACK FEMINISM

Black feminist theory posits that HIV prevention intervention programs address unique issues in the lives of poor African-American women. Helping African-American women to become more empowered merely begins the risk reduction process. Risk reduction must include the transformation of unjust social institutions that African-American women encounter from one generation to the next. Black feminist perspective can contribute to a paradigm shift in how HIV prevention interventionists think about the unjust power relations that shape black women's risk for HIV. By embracing a paradigm of intersecting oppressions of race, class, and gender to critique structural domains of power, black feminist thought re-conceptualizes the social relations of domination and resistance (Collins, 1990).

Given the continued increase in the number of new cases of HIV/AIDS among poor African-American women who use crack cocaine, we know that a simple transfer of risk reduction strategies is not

the most effective method for reversing the trend among this high-risk group. For the most part, public health scholars and practitioners have ignored African-American women’s unique history when designing and implementing risk reduction. A careful examination and appreciation for African-American women’s socialization in the United States would provide historical evidence as to how this group survives and resists harm (Gray-White, 1999; White, 1994).

New theories for HIV prevention should arise from among the new faces and factors that are disproportionately impacted by HIV (DeCarlo and Kelly, 1996).. By incorporating key components of black feminist theory into existing HIV preventions, researchers can take a closer look at what works in the lives of poor African-American women who smoke crack in designing more effective programs. Perhaps, black feminists’ most radical premise has been their rejection not only of what is concluded about black women, “but the credibility and the intentions of those possessing the power to define” (Collins, 1991a). According to Collins, when black women define themselves, they clearly reject the taken-for-granted assumption that those in positions granting them the authority to describe and analyze reality are entitled to do so.

The acronym that serves as a black feminist model for HIV risk reduction is entitled “CURES,” with each letter representing a key theme in black feminism (Table 9.2). In addition, for each theme, I have developed a module objective as well as some suggested activities that HIV prevention-focused community-based organizations can use to enhance their currently funded programs. HIV prevention program coordinators can work closely with local professors located in women’s studies, African-American studies, or sociology departments with expertise in black feminist theory for technical assistance in leading suggested discussions and activities.

TABLE 9.2. CURES: A BEHAVIORIAL CHANGE MODULE BASED ON BLACK FEMINISM

	BLACK FEMINIST THEME	MODULE OBJECTIVE	SUGGESTED ACTIVITIES
C	Controlling images	To help black women and HIV prevention counselors understand how controlling images are designed to make racism, sexism, poverty, and other forms of injustice appear to be natural, normal, and inevitable parts of everyday life	Discuss and process how specific controlling images constructed for black women continue to threaten black women’s mental and physical health
U	Unique historical experiences	To help high-risk women and HIV prevention counselors examine black women’s unique experiences in balancing work and family life under oppressive	Discuss the process of enslavement, segregated employment, and black feminization of poverty as continued barriers in the lives of black women

	BLACK FEMINIST THEME	MODULE OBJECTIVE	SUGGESTED ACTIVITIES
		conditions	
R	Race, class, and gender	To help high-risk women and HIV prevention counselors more effectively address the ways in which race, class, and gender inequalities intersect in the lives of poor black women at risk for HIV	Explore what it means to be a poor black women in the era of welfare reform and dismantling of public housing at a time when crack cocaine and HIV infection continue to disproportionately impact black women
E	Expressions of self-definition and self-valuation	To help high-risk women and HIV prevention counselors appropriately apply the transtheoretical stages of change in the lives of high-risk black women	Discuss women in the various stages of change within the context of being a high-risk black woman: precontemplation; contemplation; ready for action; action; maintenance; and relapse
S	Structure and agency	To help high-risk women and HIV prevention counselors bridge the gap between individual responsibility for HIV prevention and structural barriers	Promote economic empowerment by sponsoring intense job skills building and workplace etiquette; create volunteer experiences for Develop a Sister Advocacy Program to serve as an adult mentoring program; conduct a Graduation Ceremony to serve as an indicator of women's capability for completing risk reduction programs

In conclusion, an analysis of how women came to be at risk for HIV in the first place is at the heart of black feminist thought as critical theory. Existing public health theories can address in general that “something is wrong” in these women’s lives. However, black feminism explains high-risk black women’s dilemma from a race, class, and gender perspective in a way that helps interventionists toward a culturally relevant approach to risk reduction. Black feminism argues that change management should reflect the women’s definition of what exactly is wrong, including their accounts of how they became drug users, and how this behavior relates to their risk for HIV infection. In addition, black feminist scholars are adamant that researchers address race, class, and gender inequalities that impact poor African-American women’s ability to make permanent changes.

HIV prevention programs in the lives of poor African-American women who smoke crack tend to focus on the individuals, while failing to confront institutionalized oppression. Even when such interventions claim to be culturally relevant in addressing these women’s issues, they often emphasize internalized oppression, rather than structural oppression. Black feminist thought challenges both personal and institutional malfunctions as barriers to successful risk reduction. While it is critical that each woman examines her own experiences in the context of larger societal systems of domination, she may be ill-equipped to do so in the short term. It is in this context that I as an African-American woman within the HIV prevention community can help in interpreting the macro issues of racism, sexism, and poverty in relation to high-risk behaviors.

As I have never used crack cocaine, been homeless, been beaten, or been pregnant, as a woman of color these still are issues that impact my life. As Dr. King so eloquently put it, “we are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one of us directly, affects all indirectly.” Thus, in realizing that my liberation remains tied to the poorest among my race and gender, I do not conclude in this book,, rather I commit to clinical research and activism that results in the elimination of health disparities. As articulated throughout this book, HIV prevention in the future will need to address both individual and institutional change. Public health strategies for HIV prevention will be more effective if they integrate black feminism into the design, implementation, evaluation, and activist stages of HIV programs. The women’s stories help toward such new approaches by clarifying structure and agency in their lives as it relates to HIV infection and crack cocaine use. It is their voice about their lived experiences and best strategies for changing their behavior that should be the loudest in developing the next generation of HIV prevention aimed at addressing the unique and devastating toll this disease as taken in the lives of black women.

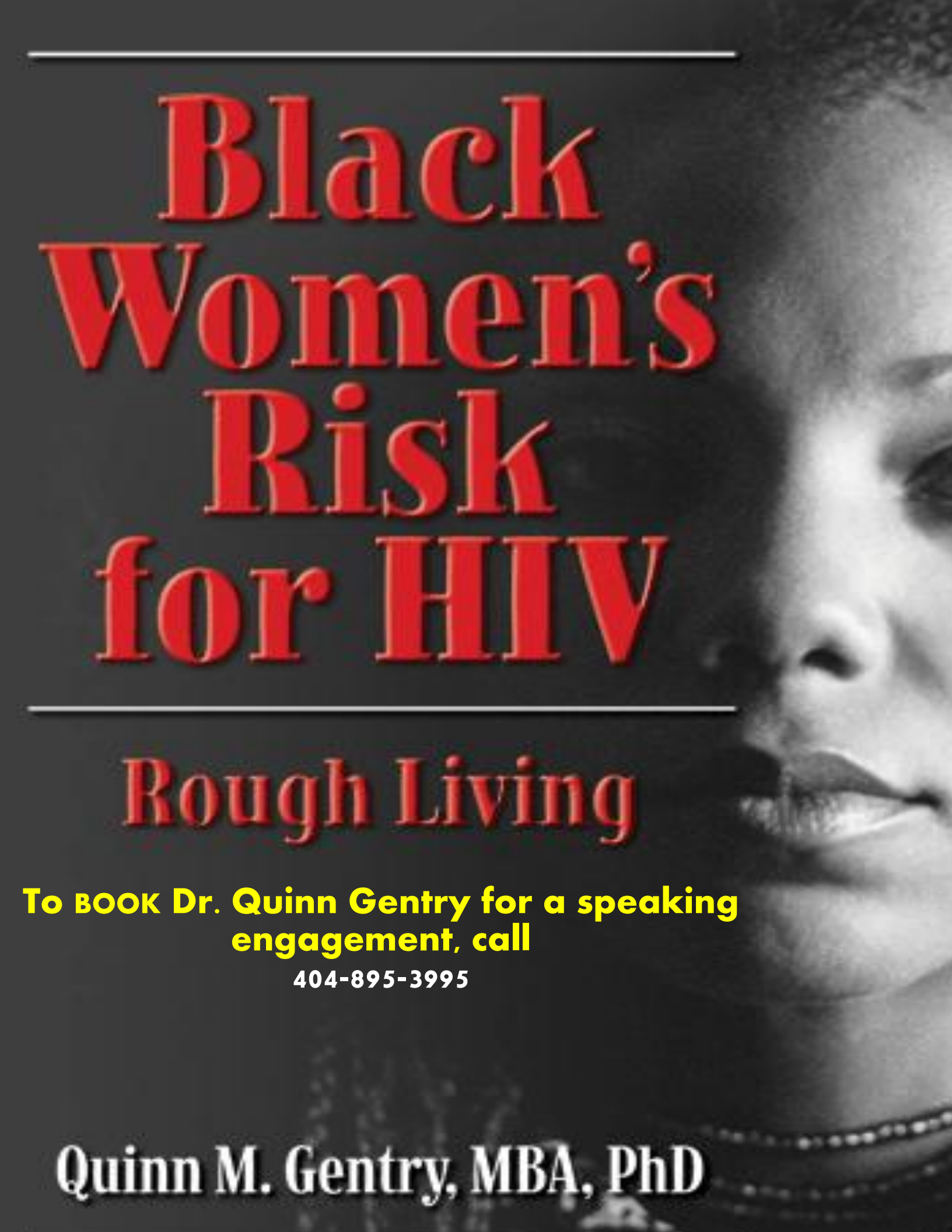
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A black and white close-up photograph of a woman's face, showing her eyes, nose, and mouth. She is looking slightly to the right of the camera. The lighting is dramatic, with strong highlights and deep shadows.