



Invited paper

Preventing HIV in U.S. Women and Girls: A Call for Social Action

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A B S T R A C T

Successes in HIV prevention efforts in the U.S. have resulted in drastic reductions in the number of new infections in the U.S. among white gay men and injection drug users, a stabilization in overall annual rates of new HIV infections, and near eradication of mother-to child transmission of HIV. Despite this remarkable progress, the proportion of AIDS cases in women has slowly, quietly, and steadily increased from 7% in 1985 to 25% in 2008.

The fact the prevention efforts have not reduced HIV spread among women suggests that targeting the individual behaviors of women to prevent HIV acquisition is not a sufficiently effective public health strategy. Interventions that more broadly address the needs of women and their families, and address the contextual factors in which HIV risk occurs are more likely to lead to measurable and sustainable progress. Over the past 30 years, we have seen the U.S. HIV epidemic in women become similar to patterns of HIV risk among women in the developing world. In 2009, 85% of women who acquired HIV became infected through sex with a man and the majority (83%) of them were non-white women. Efforts to understand these immense disparities and create gender-responsive strategies must be a priority within our National HIV/AIDS Strategy.

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Women Don't Get AIDS, They Just Die From It!
—Act Up Campaign, 1991

as well as from infecting other men. Little attention was focused on how to prevent women from acquiring HIV.

Advocates Demand Attention to Women and HIV

The History of HIV in Women in the United States

In 1981, five women had been reported to have an unexplained community-acquired cellular immune deficiency (Masur et al., 1982) that seemed to be similar to those being reported among gay men and injection drug users. Although HIV had not yet been identified, this provided an early glimpse into the fact that women were equally vulnerable.

By 1990, nearly 10 years into the HIV epidemic, more than 15,000 female AIDS cases had been reported in the United States (U.S. Centers for Disease Control and Prevention [CDC], 1992a). However, the focus on women and HIV during the first decade of the epidemic seemed to center around a view of them as vectors of disease. A great deal of public attention focused on how to prevent an HIV-infected woman from infecting her unborn child,

In 1991, a decade after the acquired immune deficiency syndrome (AIDS) had been defined, approximately 4.5 million women around the globe were believed to be HIV positive (World Health Organization, 1992). Despite this staggering fact, little research and even fewer presentations at major scientific conferences were focused on women. Activists around the world started to highlight this issue, and women began to organize. The slogan, “Women Don't Get AIDS, They Just Die From It!” was brought to the 1991 International Conference on AIDS in Florence, Italy, by ACT UP New York members seeking attention to the plight of women and became a common placard in subsequent years of protest. In 1992, at the VIII International Conference on AIDS in Amsterdam, the International AIDS Women's Caucus was formed to promote the inclusion of women's issues at these conferences and all global forums addressing HIV. At the 1993 International Conference on AIDS in Berlin, women at the conference—many of them living with HIV—were so angry about their invisibility that they stormed the plenary stage in protest.

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These and other important grassroots efforts led to significant changes including CDC's 1993 decision to expand AIDS case definitions to include cervical cancer as an AIDS-defining illness (CDC, 1992b). Many women, despite being HIV positive and very ill, had never received an AIDS diagnosis before this change because the original clinical definition of AIDS did not include manifestations specific to women. This inaccuracy resulted in women getting delayed access to important resources, including disability benefits, and was a clear indicator of the consequences of failure to invest in research on how HIV was manifesting in women as opposed to men.

From Vectors to Victims

In 1994, a study by the U.S. AIDS Clinical Trials Group's (ACTG) called ACTG Protocol 076 demonstrated that zidovudine, the first drug licensed to treat HIV, could reduce perinatal transmission of HIV by two thirds when administered to HIV positive pregnant women during pregnancy and their newborn babies immediately after delivery (Connor, Sperling, & Gelber, 1994). This became one of the greatest HIV prevention successes to date. In some ways, this discovery may have allowed a more rapid shift away from studying women primarily as vectors of HIV disease.

The widespread perception that women with HIV in the United States were mostly injection drug users and/or sex workers was challenged in 1995 when heterosexual contact was documented by the CDC as the main source of HIV exposure for women (CDC, 1995). This clarified the fact that the majority of women were becoming infected through a male sexual partner whose HIV status was likely unknown to them. During this time AIDS, became the third leading cause of death in U.S. women aged 25 to 44 and the leading cause of death in Black women in this age group (CDC/National Center for Health Statistics, 1997).

The arrival of highly active anti-retroviral treatment or the new "drug cocktails" in 1997 dramatically changed the health profile of many people living with HIV. By 1999, HIV had dropped to the fifth leading cause of death for U.S. women aged 25 to 44 as a consequence of these new medicines, and became the third leading cause of death among African-American women in the same age group (CDC/National Center for Health Statistics, 2001). Between 2000 and 2004, the estimated number of AIDS cases in the United States increased by 10% among females (National Institute of Allergy and Infectious Diseases, 2008). The "leading causes of death" statistics remained unchanged in this time period; however, by 2006 women accounted for 27% of annual new HIV infections and 25% of those living with HIV (Hall et al., 2008). As more and more women were infected by their primary male partner, it became clear that women were not really vectors of infection but, rather, in some eyes, they were victims of infection. As in the developing world, having a primary male partner became the number one risk factor for women getting HIV.

The Current HIV/AIDS Pandemic in U.S. Women

Women's share of all AIDS diagnoses from 1985 to 2009 increased from 7% in 1985 to 25% in 2008 (CDC, 2011). Although it would be preferable to report HIV trends rather than AIDS trends, HIV surveillance is more speculative because it was not standardized before 1991; currently, those data are only based on the 40 states with confidential reporting from which data are available. The CDC suggests HIV surveillance data be used with

caution because they may not provide the full picture regarding trends (CDC, 2011).

Even with the cautionary note, the latest HIV surveillance data show women accounted for one in four new HIV cases with a total of 10,255 adult and adolescent females diagnosed with HIV infection in 2009. Four in 10 of all new HIV infections among women occurred in adolescents and young women (13- to 34-year-olds). Most (85%) are attributed to heterosexual contact and are among women of color (65% African American, 16% Hispanic/Latino; CDC, 2011). These numbers may be underestimates given the absence of data from states with known high incidence among women (i.e., California, Maryland, and Washington, DC). For example, in the District of Columbia, it is estimated that 3% of Black women are infected with HIV (District of Columbia Department of Health, 2008). Understanding this large, disproportionate racial and ethnic disparity in the distribution of HIV/AIDS cases among women demands an analysis, not only of the gender issues involved, but also broader social, economic, and cultural issues.

Traditional Theoretical Models in HIV Prevention are Inadequate for Women

Despite important efforts (see Depadilla, Windle, Wingood, Cooper, & Diclemente, 2011; Traube, Holloway, & Smith 2011), there continues to be a dearth of comprehensive and well-tested theoretical models specifically for preventing HIV among women. Repeated requests over the past two decades have been made for increased attention to this area—and specifically to the contexts in which women's HIV risk occurs (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009; Ehrhardt & Exner, 2000; Gómez, Gregorich, & Marin, 1996; Hodder et al., 2010; Quinn & Overbaugh, 2005; Wingood & DiClemente, 2000; Zierler & Krieger, 1997).

During the first decade of the AIDS epidemic, health behavior theorists identified many important factors associated with an individual's ability to use or request condoms, including peer norms concerning safer sex (Kelly et al., 1991; Joseph, Montgomery, Emmons, & Kirscht, 1987), one's attitude about practicing safer sex (Fishbein & Ajzen, 1981), one's perceived ability to practice safer sex even when barriers are present (also referred to as self-efficacy; Bandura, 1990), and one's perception of vulnerability to HIV (Catania, Kegeles, & Coates, 1990). Although these individual factors have proven to be vital and significant components of successful individual sexual behavior change, they do not address any of the cultural, socioeconomic and other contextual realities that affect sexual interactions between men and women and further challenge the capacity for individual behavior change (Traube et al., 2011). Over a decade ago, Amaro and Raj (2000) noted:

For many years, research on women's HIV risk behaviors has ignored the dynamics of intimate relationships, male partner attitudes towards safer sex, male-perpetrated violence against women partners, the role of gender based power, and the role of socioeconomic factors as elements in establishing HIV risk. (p. 724)

Since that time, we have seen more research on these broader contextual factors, but it has not resulted in any significant expansion of effective HIV prevention interventions for women (Hodder et al., 2010; Hogben & Leichter, 2008). Existing models of behavioral risk reduction continue to be criticized because of their sustained inattention to gender roles, sexuality, cultural

differences, women's socioeconomic status and power imbalances in heterosexual relationships between men and women (Depadilla et al., 2011; El-Bassel et al., 2009; Kim, Pronvk, Barnett, & Watts, 2008; Marín, 2003; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Scott, Gilliam, & Braxton, 2005).

HIV prevention researchers continue to assert that there is a vital need for HIV prevention programs for Latina and African-American women that address gender, socioeconomic status, and specific cultural issues that may exist in their environments (El-Bassel et al., 2009; Moreno, 2007). Gupta (2000) wisely stated over a decade ago that before these issues can be seriously addressed, we must first recognize and understand them so that we can publicly discuss how power differentials in gender and sexuality influence the observably escalating rates of HIV. Theoretical models that do not recognize these factors have given rise to unrealistic interventions, including those that expect women to step out of their cultural frameworks to change behaviors and, thus, reduce their HIV risk (Hahm, Lee, Rough, & Strathdee, 2011).

In 2010, the National Institutes of Health Office of AIDS Research convened the *Social and Behavioral HIV Prevention Research Think Tank*. This meeting brought together over 100 experts from academic institutions, government agencies, community constituency groups, and the nongovernment sector to make recommendations regarding priorities for HIV-related social and behavioral science research, particularly in the context of the new *National HIV/AIDS Strategy for the United States*. Among many important recommendations was the need to promote research on theory development that can explain how multilevel pathways, forces, and social actors influence HIV epidemics; and to promote research on the social construction of vulnerability, marginalizing conditions, and resilience, particularly for African-American and Latina women (NIH Office of AIDS Research, Recommendations from the OAR Social and Behavioral HIV Prevention Research Think Tank, unpublished report, 2010).

In fact, one can speculate that perhaps targeting women's individual behaviors may be our least powerful tool in preventing HIV infection in women (Krishnan, et al., 2008). What makes women susceptible to HIV is very complex, and requires multiple levels of intervention, and commitment to social change regarding the status of women in the United States and around the globe.

Factors Related to Women's Vulnerability to HIV

Individual-Level Factors

Female anatomy, physiology, and sexually transmitted infections

It has long been noted that a woman is more likely to become infected with HIV than a man during vaginal sex owing to the larger surface area for possible HIV exposure in the vaginal cavity compared with the penis (Alexander, 1990). Variation in vaginal lubrication production in women owing to hormonal fluctuations or medication side effects can also create long-term or temporary windows of increased susceptibility to HIV (Kaushic, Roth, Anipindi, & Xiu, 2011). Intravaginal practices such as the insertion of products to dry or tighten the vagina (most common in African cultures to increase pleasure) or vaginal cleaning with soap can lead to irritation or tearing that is believed to facilitate HIV transmission (Low et al., 2011; Myer, Kuhn, Stein, Wright, & Denny, 2005).

The presence of other sexually transmitted infections (STIs) increases the potential for transmission of HIV. Because women

are more likely than men to be asymptomatic when infected with an STI, they are less likely to be screened or effectively treated and this also raises their risk for acquiring HIV. Women are reported to have higher rates of chlamydia and gonorrhea compared with men (CDC, 2010). Rates of chlamydial infections among women have been increasing annually since the late 1980s. In 2009, the overall rate of chlamydial infection in the U.S. among women (592.2 cases per 100,000 females) was almost three times the rate among men (219.3 cases per 100,000 males); the rate in Black women was nearly 8 times higher than that in white women; and rates were slightly higher in the Southern region of the United States. From 1996 to 2009, gonorrhea rates in men and women were similar, but slightly higher in women over the past decade. In 2009, the gonorrhea rate in women was 105.5 cases per 100,000 population compared with a rate of 90.8 in men. Cases were significantly higher in the Southern region of the United States. As with chlamydia, gonorrhea rates in women were highest among those aged 15 to 24 years. The gonorrhea rate among Black women was 17 times higher than that in White women (CDC, 2010).

Lack of information and skills

There is limited research on the general population's levels of knowledge of male and female anatomy, or more specifically sexual anatomy (Shedlin & Amastae, 2011; Weinman, Yusuf, Berks, Rayner, & Petrie, 2009), but anecdotal data from HIV prevention providers suggest the many women still lack basic information about male and female anatomy and how their bodies work. This lack of education is often related to cultural norms and sexual silence—factors that can make women uncomfortable with open discussion of sexual matters and teaching children about sex at an early age. Low levels of literacy and language barriers can exacerbate these issues and decrease women's access to vital information that would help her prevent becoming exposed to HIV (Rios-Ellis et al., 2008).

Low perception of risk

The fact that so many women do not know how they were exposed to HIV when they first learn of their HIV infection suggests that a low perception of vulnerability to HIV persists among women. For example, in the most recent HIV surveillance report for New York, 60% of women diagnosed with HIV in 2008 did not know how they had become infected and it is assumed that a large proportion will be reclassified to the heterosexual transmission category (Bureau of HIV/AIDS Epidemiology, AIDS Institute, New York State Department of Health, 2010). With some exceptions, women tend to assume their primary male partners are monogamous, heterosexual, and not injecting drugs (Gómez, Chang, & Martinez, 2008). However, few are likely to confirm or question these assumptions with their partners, even when faced with situations where there is a high probability that HIV risk may have occurred, such as incarceration (Comfort, Grinstead, McCartney, Bourgeois, & Knight, 2005).

Sexual behavior patterns

Linking the previously discussed individual factors with actual sexual behaviors, we begin to see how women continue to be exposed to HIV. In a U.S. population-based survey of women, the majority of women ages 18 to 49 reported engaging in vaginal sex in the previous 90 days. Among 18- to 24-year-olds, one fourth of those cohabitating and one fifth of those married also reported anal sex in the previous 90 days (Herbenick et al., 2010). Levels of reported condom use during the last 10 vaginal events were quite

low (18.4%). Even fewer women reported condom use during anal sex (13.2%), the sexual act with the greatest risk for transmitting HIV (Reece et al., 2010). Black and Latina women reported higher rates of condom use for most recent vaginal intercourse compared with White women, but differed by age. Black women reported using condoms during 33% of the last 10 vaginal events, with higher rates among 18- to 24-year-olds (55%), slightly lower through their 40s (24%), and slightly higher for women in their 50s (32%) and 60s (29%). Among Latinas reporting vaginal intercourse in the past year, condoms were being used for a mean of 18% of the past 10 events, and similar to Black women, reported highest rates among those aged 18 to 24 years (40%), lower among 25- to 29-year-olds (24%), and then dropping below 17% in all subsequent age groups (Dodge et al., 2010).

In the absence of other complex contextual challenges, if a woman has an untreated STI, does not know how to identify physiological symptoms or examine her genitalia, believes she has a monogamous uninfected partner, and engages in unprotected vaginal or anal sex, she is already quite vulnerable for acquiring HIV.

Couple-Level Factors

Traditional gender norms

Gender, culture, and power each may affect women's ability to establish and maintain safer sex practices with sexual partners. Although there are many diverse cultures that exist with different norms and cultural expectations, one consistent element found in all cultures is the differential roles of men and women (Gupta, 2000; Manji, Peña, & Dubrow, 2007; Strebel et al., 2006).

The interaction of sexual gender norms with cultural norms continues to exacerbate these issues for women (Crawford, 2005; Gómez et al., 1996; Marecek, Crawford, & Popp, 2004; Peragallo, DeForge, Khoury, Rivero, & Talashek, 2002; Wyatt, Williams, & Meyers, 2008). Latinas, particularly immigrant women, have been characterized as being super-mothers—passive, obedient, self-sacrificing, and subordinate to men (Gonzalez-Guarda, Vasquez, Urrutia, Villarruel, & Peragallo, 2011). The term *Marianismo* has been coined to refer to how Latina women should behave and think. In a traditionally *machista* society, women do not talk with men about sex and doing so may be viewed as distasteful and/or suggestive of sexual promiscuity (Pérez-Jiménez, Seal, & Serrano-García, 2009).

African-American women are also expected to conform to certain sexual gender norms that have been historically imposed by the dominant White culture (see Wyatt [1997] for historical context). In a recent study of African-American women, Nguyen et al. (2010) found that African-American women's gender roles fell within three domains: Caretaking/mindful, interpersonal sensitivity, and persistent/active coping. Women who scored higher on the interpersonal sensitivity domain reported less condom use and intentions. The persistent/active coping domain was associated with more condom negotiation efficacy and use.

For both African-American and Latina women, perceived gender norms and roles can contribute to their struggles in condom negotiation efficacy and use with male partners, but as Nguyen et al.'s (2010) findings suggest, some of these cultural influences can also empower women and further investigation of how this could be applied to prevention interventions is warranted (Williams, Allen, & Padian, 2008).

Power in relationships

Power differentials continue to exist in heterosexual relationships and must not be ignored when examining women's sexual risk for HIV transmission. Before the introduction of the female condom, women in sexual encounters with men had essentially two choices in preventing exposure to HIV: Either to engage in nonpenetrative sex or require their male partner to use a condom. Proponents of simple condom promotion strategies often fail to consider gender-based power relationships and how power imbalances may influence a woman's ability to demand condom use. The presence of physical or sexual violence—as well as more subtle sexual coercion—within heterosexual relationships is not uncommon (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005; Gielen et al., 2007; Plotzker, Metzger, & Holmes, 2007). Abused or coerced women also tend to adhere to more traditional gender roles and may relinquish all sexual decision-making power to their male partners (Arriola, Lounden, Doldren, & Fortenberry, 2005; Gonzalez-Guarda et al., 2011). The fear of a partner's negative response impedes many women from initiating safer sex practices (Hahm et al., 2011; Wingood & DiClemente, 2000).

Structural Risk Factors for HIV: The Social Status of Women

In addition to the factors that may affect HIV vulnerability at the individual or couple levels, broad social factors also influence the context in which HIV risk occurs. Poverty, discrimination, and violence against women were absent from the early individual behavior-based models of risk factors for HIV infection; however, as we begin to develop a better understanding of the social determinants of health (Adler, et al., n.d.; Williams, 2005), we have come to recognize some of these social conditions may be the fundamental etiology of HIV infection in women.

The synergy of being a woman of color and of low income becomes extremely pertinent in the lives of many African-American and Latina women in this context. Living with few or fragile economic resources and daily facing racism, discrimination, unstable housing, and violence further places them at risk for HIV (Adimora & Schoenbach, 2005), not only because of the potential lack of access to HIV prevention services, but the added psychological and physical consequences of these stressors. Social stress (Kopp, Skrabski, Szekely, Stauder, & Williams, 2007) is considered an important pathway influencing well-being and health directly, as well as indirectly through its influence on health-seeking behaviors (Clougherty, Souza, & Cullen, 2010).

Economics

Many have characterized HIV as a disease of poverty, but it is important to acknowledge that in the early days of the epidemic, HIV incidence in the United States and in many African nations was highest among more affluent, educated, and more mobile members of these societies (Kim et al., 2008; Piot, Greener, & Russell, 2007). Piot et al. (2007) note that many researchers point to economic and gender inequalities, rather than to poverty itself, as factors influencing sexual behavior and potential for HIV transmission.

The links between poverty and HIV vulnerability for women in the United States are clearly complex and multidimensional. The notion that poverty is the main driver of HIV incidence in women is too simplistic and gender inequality is likely a more significant factor (Gillespie, Kadilaya, & Greener, 2007). Because HIV is acquired primarily through sexual contact, preventative

behaviors are transactional by nature, and unlike other health conditions linked with poverty, HIV underscores the economic perspective of reward and dependency, which influences the extent to which women are able to make and exercise choices about sexual behaviors (Kim et al., 2008).

Poverty, addiction, and lack of food may motivate women to engage in transactional sex to procure drugs or food and shelter for themselves and their children (Jenness et al., 2011). Women's economic dependence on their partners may also make it difficult for them to insist on safer sex (e.g., condom use) (Gillespie et al., 2007) and may induce them to tolerate relationships that are unstable or even violent (Gielen et al., 2007; Gonzalez-Guarda et al., 2011; Moreno, Morrill, & El-Bassel, 2011).

Lack of health insurance among lower income women can also contribute to increased HIV risk because it prevents many from seeking preventative health services. Approximately 19.1 million women in the United States are uninsured. Low-income women in the United States are more than twice as likely to be uninsured than the general population of women (42% vs. 20%). Less educated and Latina women also report higher proportions of being uninsured than the general population of women (38%, 39%, and 20%, respectively; Kaiser Family Foundation, 2010).

Use of race/ethnicity as a marker for social class in HIV/AIDS incidence oversimplifies the link between poverty and HIV. As stated by Williams, Mohammed, Leavell, and Collins (2010, p. 69), "race reflects multiple dimensions of social inequality and individual and household indicators of SES capture relevant but limited aspects of this phenomenon." Although African Americans and Latinos are overrepresented among those living in poverty (35% and 34%, respectively, versus 13% among Whites; Kaiser Family Foundation, 2011), the higher rates of AIDS and HIV infection among African-American and Latina women cannot be simply attributed to poverty.

Recent analysis in the developing world actually suggests that relative wealth seems to have a mixed influence on HIV risk depending on an array of contextual factors. In the most comprehensive, multi-country study to date conducted by Mishra et al. (2007), the residual effect of wealth was statistically insignificant after controlling for other important variables. There are very few studies that are able to relate wealth or poverty to the incidence of HIV, but the ones that have been conducted show the highest risk of infection in the middle wealth group (Gillespie et al., 2007; Kim et al., 2008; Piot et al., 2007).

Unfortunately, the lack of reported surveillance data regarding socioeconomic status and HIV incidence by the CDC precludes our ability to get a more precise picture of the range of socioeconomic status among those becoming infected. Interestingly, consistent with data from the developing world, African-American and Latina women who participated in a qualitative research study in Northern California suggested that women who have some level of income versus very poor women were likely to be at higher risk for HIV because money allowed them to engage in more social activities, such as going on vacations or to bars where they may be more likely to "hook-up" with new sexual partners (Gómez et al., 2008).

Racism, discrimination, segregation, and incarceration

Individual and institutional discrimination based on race/ethnicity can adversely affect health by limiting socioeconomic opportunities and upward mobility; and can also influence health directly (Ford & Airhihenbuwa, 2010; Williams & Mohammed, 2009). Krieger (1999) describes five pathways through which discrimination can harm health. They involve

exposure, susceptibility, and responses to 1) economic and social deprivation, 2) toxic substances and hazardous conditions, 3) socially inflicted trauma, 4) targeted marketing of legal and illegal psychoactive substances and other commodities (e.g., junk food), and 5) inadequate health care, by health care facilities and by specific providers. She also notes the relevance to health of people's varied responses to discrimination. These can range from internalized oppression and use of drugs and alcohol to reflective coping, active resistance, and community organizing to end discrimination and promote social justice.

To date, limited scientific studies have specifically measured the impacts of racism or racial discrimination in the lives of HIV-infected women, or women at risk of HIV infection (Adimora & Schoenbach, 2005; Kalichman et al., 2006). Several researchers have begun to emphasize the role of discriminatory housing and residential segregation by race as an important contributor to HIV risk (Adimora & Schoenbach, 2005; Weir, Bard, O'Brien, Casciato, & Stark, 2007; Wenzel, Tucker, Elliott, & Hambarsoomians, 2007). Adimora and Schoenbach (2005) note that segregation concentrates poverty and other detrimental social and economic influences within racially isolated groups. Segregation is also important to the structure of sexual networks, because people tend to choose sex partners from the neighborhoods where they live.

For African-American and Latina women living in segregated neighborhoods, they are also likely to be living among men entering and exiting the correctional justice system. African-American and Latino men combined constitute the majority (68%) of men behind bars (Golembeski & Fullilove, 2008). Hammett, Harmond, and Rhodes (2002) estimate that one quarter of all persons living with HIV have passed through a correctional facility. For women welcoming back partners released from prison, there is an extremely high risk of HIV exposure given the various activities in prison that can lead to HIV exposure including tattooing, injection drug use, and sex; however, few women opt to use condoms with these male partners upon their return (Comfort et al., 2005).

Using a theoretical perspective that places social conditions as a fundamental cause of disease, excess HIV risk among African Americans and Latinas can be considered an underlying consequence of discrimination in housing, earning power, unemployment, incarceration, and education (Fullilove, 2006; Quinn & Overbaugh, 2005). Living amidst social conditions and constraints produced by racial discrimination may be associated with an increased risk for drug use, partnerships with high-risk sexual partners, and adoption of income generation strategies that may involve sexual risk taking and drug use (Kim et al., 2008).

Sexual violence against women

In 2008, the National Crime Victimization Survey found that over 165,000 women had been victims of rape or sexual assault (Rand, 2009). Although the estimate of violence is high, most sources believe the prevalence of violence against women and children is underestimated. Multiple studies have demonstrated that a history of child sexual assault or rape is linked with HIV risk (Clum et al., 2011; Paul, Catania, Pollack, & Stall, 1999; Wilson & Widom, 2011; Wyatt, Meyers, & Loeb, 2004). A meta-analysis across studies reveals an association between an experience of sexual violence (an inherently social phenomenon) and HIV risk behaviors in women (Arriola et al., 2005).

Women who experience sexual violence may not have received sufficient posttrauma intervention (see the article by

Wyatt et al. elsewhere in this issue) and subsequently may be driven to coping mechanisms such as substance use and/or increased sexual risk behaviors that can lead to repeated trauma and HIV infection. HIV prevention interventions cannot be expected to fully address the psychological impact of violence.

Gender-based violence and sexual exploitation violate women's basic human rights. Combating sexual violence against women in the United States and around the world requires fundamental social change that protects women's rights and promotes gender equity in economic and social spheres.

Conclusion

The promise of an effective, affordable, and accessible biomedical solution to the spread of HIV among women continues to elude us (Roehr, 2011), underscoring the need for continued broad, multilevel strategies grounded within the reality of women's lives.

Many competing forces can rob women of their ability to make independent decisions during sexual and injection drug-related encounters with men. Some of these can be addressed within the context of an HIV prevention intervention. Some cannot. While remaining aware of the value of some of the HIV prevention messages currently targeted at women, one must also question whether the women at greatest risk for becoming infected with HIV are getting the real tools they need to preventing HIV transmission.

The task of enabling most African-American and Latino women to remain uninfected with HIV goes well beyond learning how to use condoms, learning how to ask for condoms during sex through role-playing, or learning self-motivating statements such as, "I'm worth protecting from HIV." Although these are important and useful skills, they are unlikely to help the woman who believes she must please her man at all cost, the self-sacrificing woman, the woman who will not risk losing economic support, the woman who experiences daily sexual coercion from her partner, or the woman who uses sex and drugs as a way to cope with the shame of childhood sexual abuse or rape.

We must consider the complexities that shape women's HIV risk and not restrict ourselves to the traditional cognitive models of behavior change that have been used thus far in HIV prevention interventions for women. It is evident that this ever-changing pandemic requires constant retargeting of prevention services and continuous updating of services addressing women's needs. Prevention efforts need to explore more difficult topics related to staying uninfected, such as power imbalances, intimate partner violence, and racism.

HIV prevention interventions for women should not be solely about HIV. They should be about learning self-defense. They should be about learning how to start your own business. They should be about learning how to become an activist at the steps of city hall. They should teach people that women and children have rights in our society. They should teach women how to support other women and to become owners of their own destiny.

HIV prevention interventions must also target the men and women who are making the policy decisions that affect women's lives, such as those determining their access to public housing and income security through public assistance and social security. Shutting down public housing units in this country may make sense in urban development plans, but what of the health and economic consequences for the women and children who

have been living there? What happens to their HIV risk when they lose their homes?

Another category of HIV prevention interventions that are critical to saving women's lives are those that target men, particularly heterosexual and bisexual men. We must find a way to support men and their sexuality in a way that will prevent them from becoming infected with HIV, or if already infected, providing them with tools and resources to prevent transmission. In 2009 in the United States, 85% of women and 78% of men who became HIV-positive were infected during sex with a man (CDC, 2011). This tragic reality demands attention and social action.

Men and women must come together in demanding real changes in our social norms and policies and in how men and women interact with each other about sex. Together, we must teach our children how to create a society where sex is not a man's prerogative and not something for which a woman's well-being can be sacrificed.

Lamentably, many of the important HIV prevention recommendations set forth during the Office on Women's Health/UNAIDS Forum in Washington, DC, entitled "Bringing Gender Home: Implementing Gender-Responsive HIV/AIDS Programming for U.S. Women and Girls" echo the voices of women from around the world spoken some 20 years ago in New York, Florence, Amsterdam, and Berlin. Yes, some progress has been made and new technologies in data collection and biologically based prevention strategies raise hope; however, the dismantling of structural barriers, the perseverance of racial discrimination, and the underprivileged social status of women remain our greatest challenges.

Thirty years after the discovery of AIDS, we remain at risk of perpetuating women's vulnerability to HIV indefinitely if we do not expand our HIV prevention strategies to address the context of women's lives. The new National HIV/AIDS Strategy displays a renewed focus on men who have sex with men, but we cannot allow this to result inadvertently in the invisibility of women. Instead, let us move toward comprehensive biomedical, behavioral, and structural interventions that not only bring to an end the spread of HIV, but also improve the quality of our lives now and for future generations.

We cannot wait for another tragedy or unsuspecting virus to serve as a wake-up call for action. It is time to join forces across all societies of the world and to demonstrate how the elevation of women's social status will lead to a healthier and wealthier world for all.

References

- Adimora, A. A., & Schoenbach, V. J. (2005). Social context, sexual networks and racial disparities in rates of sexually transmitted infection. *Journal of Infectious Diseases*, 191, S115–S112.
- Adler, N., & Stewart, J. (with S. Cohen et al.). (n.d.). Reaching for a healthier life: Facts on socioeconomic status and health in the U.S. The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health. Available: www.macses.ucsf.edu.
- Alexander, N. J. (1990). sexual transmission of human immunodeficiency virus: Virus entry into the male and female genital tract. *Fertility and Sterility*, 54, 1–18.
- Amaro, H., & Raj, A. (2000). On the margin: Power and women's. *Sex Roles*, 42, 723–749.
- Arriola, K. R., Lounden, T., Doldren, M. A., & Fortenberry, R. M. (2005). A meta-analysis of the relationship of child sexual abuse to HIV risk behavior among women. *Child Abuse & Neglect*, 20, 725–746.
- Bandura, A. (1990). Perceived self-efficacy in the exercise of personal agency. *Journal of Applied Sport Psychology*, 2, 128–163.

- Bureau of HIV/AIDS Epidemiology (BHA), AIDS Institute, New York State Department of Health (NYSDOH). (2010). HIV/AIDS Annual Surveillance Report. Available: <http://www.nyhealth.gov>.
- Caetano, R., Field, C., Ramisetty-Mikler, S., & McGrath, C. (2005). The five year course of intimate partner violence among White, Black and Hispanic couples in the United States. *Journal of Interpersonal Violence*, 20, 1039–1057.
- Catania, J. A., Kegeles, S. M., & Coates, T. J. (1990). Strategies for modifying sexual behavior for primary and secondary prevention of HIV disease. *Journal of Consulting and Clinical Psychology*, 58, 57–69.
- Clougherty, J. E., Souza, K., & Cullen, M. R. (2010). Work and its role in shaping the social gradient in health. *Annals of the New York Academy of Sciences*, 1186, 102–124.
- Clum, G. A., Chung, S. E., Ellen, J. M., Perez, L. V., Murphy, D. A., Harper, G. W., et al. (2011). Victimization and sexual risk behavior in young, HIV positive women: Exploration of mediators. *AIDS and Behavior*. Mar 31 [Epub ahead of print].
- Comfort, M., Grinstead, O., McCartney, K., Bourgeois, P., & Knight, K. (2005). "You cannot do nothing in this damn place": Sex and intimacy among couples with an incarcerated male partner. *Journal of Sex Research*, 42, 3–12.
- Connor, E. M., Sperling, R. S., & Gelber, R. D. (1994). Reduction of maternal-infant transmission of human immunodeficiency type 1 with zidovudine treatment. *New England Journal of Medicine*, 331, 1173–1180.
- Crawford, M. (2005). *Transformations: Women, gender and psychology*. New York: McGraw-Hill.
- Depadilla, L., Windle, M., Wingood, G., Cooper, H., & Diclemente, R. (2011). Condom use among young women: Modeling the theory of gender and power. *Health Psychology*, 30, 310–319.
- District of Columbia Department of Health, D.C. HIV/AIDS Epidemiology Update, 2008. Available: <http://www.dchealth.dc.gov>.
- Dodge, B., Reece, M., Herbenick, D., Schick, V., Sanders, S. A., & Fortenberry, J. D. (2010). Sexual health among US Black and Hispanic men and women: A nationally representative study. *Journal of Sexual Medicine*, 7(Suppl. 5), 330–345.
- Ehrhardt, A. A., & Exner, T. M. (2000). Prevention of sexual risk behavior for HIV infection with women. *AIDS*, 14(Suppl.), S53–S58.
- El-Bassel, N., Caldeira, N. A., Ruglass, L. M., & Gilbert, L. (2009). Addressing the unique needs of African American women in HIV prevention. *American Journal of Public Health*, 99, 996–1001.
- Fishbein, M., & Ajzen, I. (1981). On construct validity: A critique of Miniard and Cohen's paper. *Journal of Experimental Social Psychology*, 17, 340–350.
- Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health*, 100(Suppl. 1), S30–S35.
- Fullilove, R. E. (2006). African Americans, health disparities and HIV/AIDS: Recommendations for confronting the epidemic in black America. A report of the National Minority AIDS Council. Available: <http://www.nmac.org/index/grpp-publications>.
- Gielen, A. C., Ghandour, R. M., Burke, J. B., Mahoney, P., McDonnell, K. A., & O'Campo, P. (2007). HIV/AIDS and intimate partner violence: Intersecting women's health issues in the United States. *Trauma, Violence & Abuse*, 8, 178–198.
- Gillespie, S., Kadiyala, S., & Greener, R. (2007). Is poverty or wealth driving HIV transmission? *AIDS*, 21, S5–S16.
- Golembeski, C., & Fullilove, R. (2008). Criminal (in)justice in the city and its associated health consequences. *American Journal of Public Health*, 98(Suppl.), S185–S190.
- Gómez, C. A., Chang Y. J., & Martinez, A. (2008, August 3–8). Friends versus partners: How socio-economic class distinguishes predictors of condom use with primary partners among Latina women. XVII International AIDS Conference, Mexico City.
- Gómez, C. A., Gregorich, S., & Marin, B.V. (1996). Proceedings from Sexual Disempowerment: A Cultural Reality for HIV Prevention Efforts Targeting U.S. Latina Women, XI International Conference on AIDS. Vancouver, BC, Canada.
- Gonzalez-Guarda, R. M., Vasquez, E. P., Urrutia, M. T., Villarruel, A. M., & Peragallo, N. (2011). Hispanic women's experiences with substance abuse, intimate partner violence, and risk for HIV. *Journal of Transcultural Nursing*, 22, 46–54.
- Gupta, G. R. (2000). Proceedings from gender, sexuality, and HIV/AIDS: The what, the why and the how, XIII International AIDS Conference. Durban, South Africa. Canadian HIV/AIDS Policy and Law Review, 5, 86–93.
- Hahm, H. C., Lee, J., Rough, K., & Strathdee, S. A. (2011). Gender power control, sexual experiences, safer sex practices, and potential HIV risk behaviors among young Asian-American women. *AIDS and Behavior*. Jan 23 [Epub ahead of print].
- Hall, H. I., Song, R., Rhodes, P., Prejean, J., An, Q., Lee, K. M., et al. (2008). Estimation of HIV incidence in the US. *Journal of the American Medical Association*, 300, 520–529.
- Hammitt, T. M., Harmon, M. P., & Rhodes, W. (2002). The burden of infectious disease among prisoners of and releases from US correctional facilities, 1997. *American Journal of Public Health*, 92, 1789–1794.
- Herbenick, D., Reece, M., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Sexual behaviors, relationships, and perceived health among adult women in the United States: Results from a national probability sample. *Journal of Sexual Medicine*, 7(Suppl. 5), 277–290.
- Hodder, S. L., Justman, J., Haley, D. F., Adimora, A. A., Fogel, C. I., Golin, C. E., et al. HIV Prevention Trials Network Domestic Prevention in Women Working Group. (2010). Challenges of a hidden epidemic: HIV prevention among women in the United States. *Journal of Acquired Immune Deficiency Syndromes*, 15(55 Suppl. 2), S69–S73.
- Hogben, M., & Leichter, J. S. (2008). Social determinants and sexually transmitted disease disparities. *Sexually Transmitted Diseases*, 35(Suppl.), S13–S18.
- Jenness, S. M., Kobrak, P., Wendel, T., Neaigus, A., Murrill, C. S., & Hagan, H. (2011). Patterns of exchange sex and HIV infection in high-risk heterosexual men and women. *Journal of Urban Health*, 88, 329–341.
- Joseph, J. G., Montgomery, S. A., Emmons, C. A., & Kirscht, J. P. (1987). Perceived risk of AIDS: Assessing the behavioral and psychosocial consequences in a cohort of gay men. *Journal of Applied Social Psychology*, 17, 231–250.
- Kaiser Family Foundation. (2010). *Women's health policy facts, women's health insurance coverage*. Publication (#6000-09). New York: Author.
- Kaiser Family Foundation. (2011). State health facts. Available: <http://www.statehealthfacts.org>.
- Kalichman, S. C., Simbayi, L. C., Kagee, A., Toefy, Y., Jootse, S., Cain, D., et al. (2006). Associations of poverty, substance use and HIV transmission risk behaviors in three South African Communities. *Social Science & Medicine*, 62, 1641–1649.
- Kaushic, C., Roth, K. L., Anipindi, V., & Xiu, F. (2011). Increased prevalence of sexually transmitted viral infections in women: The role of female sex hormones in regulating susceptibility and immune responses. *Journal of Reproductive Immunology*, 88, 204–209.
- Kelly, J. A., Kalichman, S. C., Kauth, M. R., Kilgore, H. G., Hood, H. V., Campos, P. E., et al. (1991). Situational factors associated with aids risk behavior lapses and coping strategies used by gay men who successfully avoid lapses. *American Journal of Public Health*, 81, 1335–1338.
- Kim, J., Pronvk, P., Barnett, T., & Watts, C. (2008). Exploring the role of economic empowerment in HIV prevention. *AIDS*, 4(Suppl.), 57–71.
- Kopp, M. S., Skrabski, A., Szekely, A., Stauder, A., & Williams, R. (2007). Chronic stress and social changes: Socioeconomic determination of chronic stress. *Annals of the New York Academy of Sciences*, 1113, 325–338.
- Krieger, N. (1999). Embodying inequality: A review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services*, 29, 295–352.
- Krishnan, S., Dunbar, M. S., Minnis, A. M., Medlin, C. A., Gerdtts, C. E., & Padian, N. S. (2008). Poverty, gender inequities, and women's risk of human immunodeficiency virus/AIDS. *Annals of the New York Academy of Sciences*, 1136, 101–110.
- Low, N., Chersich, M. F., Schmidlin, K., Egger, M., Francis, S. C., van de Wijgert, J. H., et al. (2011). Intravaginal practices, bacterial vaginosis, and HIV infection in women: Individual participant data meta-analysis. *PLoS Med*, 8, e1000416.
- Manji, A., Peña, R., & Dubrow, R. (2007). Sex, condoms, gender roles, and HIV transmission knowledge among adolescents in León, Nicaragua: Implications for HIV prevention. *AIDS Care*, 19, 989–995.
- Marecek, J., Crawford, M., & Popp, D. (2004). On the construction of gender, sex, and sexualities. In A. H. Eagly, A. E. Beall, & R. J. Sternberg (Eds.), *The psychology of gender*. (2nd ed). (pp. 192–216). New York: The Guilford Press.
- Marín, B. V. (2003). HIV prevention in the Hispanic community: Sex, culture, and empowerment. *Journal of Transcultural Nursing*, 14, 186–192.
- Masur, H., Michelis, M. A., Wormser, G. P., Lewin, S., Gold, J., Tapper, M. L., et al. (1982). Opportunistic infection in previously healthy women: Initial manifestations of a community-acquired cellular immunodeficiency. *Annals of Internal Medicine*, 97, 533–539.
- Mishra, V., Assche, S. B., Greener, R., Vaessen, M., Hong, R., Ghys, P. D., et al. (2007). HIV infection does not disproportionately affect the poorer in sub-Saharan Africa. *AIDS*, 21(Suppl. 7), S17–S28.
- Moreno, C. L. (2007). The relationship between culture, gender, structural factors, abuse, trauma, and HIV/AIDS for Latinas. *Qualitative Health Research*, 17, 1–13.
- Moreno, C. L., Morrill, A. C., & El-Bassel, N. (2011). Sexual risk factors for HIV and violence among Puerto Rican women in New York City. *Health & Social Work*, 36, 87–97.
- Myer, L., Kuhn, L., Stein, Z. A., Wright, T. C., Jr., & Denny, L. (2005). Intravaginal practices, bacterial vaginosis, and women's susceptibility to HIV infection: Epidemiological evidence and biological mechanisms. *Lancet Infectious Diseases*, 5, 786–794.
- National Institute of Allergy and Infectious Diseases, Department of Health and Human Services, National Institutes of Health. (2008). HIV/AIDS: HIV infection in women. Available: <http://www.niaid.nih.gov>.
- Nguyen, A. B., Clark, T. T., Hood, K. B., Corneille, M. A., Fitzgerlad, A. Y., & Belgrave, F. Z. (2010). Beyond traditional gender roles and identity: Does reconceptualisation better predict condom-related outcomes for African-American women? *Culture, Health & Sexuality*, 12, 603–617.

- Paul, Catania, Pollack, & Stall. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The Urban Men's Health Study. *Child Abuse & Neglect*, 25, 557–584.
- Peragallo, N., DeForge, B. R., Khoury, Z., Rivero, R., & Talashek, M. L. (2002). Latina's perspectives on HIV/AIDS: Cultural issues to consider in prevention. *Hispanic Health Care International*, 1, 11–23.
- Pérez-Jiménez, D., Seal, D. W., & Serrano-García, I. (2009). Barriers and facilitators of HIV prevention with heterosexual Latino couples: Beliefs of four stakeholder groups. *Cultural Diversity & Ethnic Minority Psychology*, 15, 11–17.
- Piot, P., Greener, R., & Russell, S. (2007). Squaring the circle: AIDS, poverty, and human development. *PLoS Med*, 4, e314.
- Plotzker, R. E., Metzger, D. S., & Holmes, W. C. (2007). Childhood sexual and physical abuse histories, PTSD, depression, and HIV risk outcomes in women injection drug users: A potential mediating pathway. *American Journal on Addictions*, 16, 431–438.
- Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S. L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care*, 14, 789–800.
- Quinn, T. C., & Overbaugh, J. (2005). HIV/AIDS in women: An expanding epidemic. *Science*, 308, 1582–1583.
- Rand, R. R., & Criminal victimization, 2008. (2009, September). *Bureau of Justice Statistics Bulletin*. Washington, DC: U.S. Department of Justice, National Institute of Justice.
- Reece, M., Herbenick, D., Schick, V., Sanders, S. A., Dodge, B., & Fortenberry, J. D. (2010). Condom use rates in a national probability sample of males and females ages 14 to 94 in the United States. *Journal of Sexual Medicine*, 7(Suppl. 5), 266–276.
- Rios-Ellis, B., Frates, J., D'Anna, L. H., Dwyer, M., Lopez-Zetina, J., & Ugarte, C. (2008). Addressing the need for access to culturally and linguistically appropriate HIV/AIDS prevention for Latinos. *Journal of Immigrant and Minority Health*, 10, 445–460.
- Roehr, B. (2011). HIV prevention trial in women is abandoned after drugs show no impact on infection rates. *British Medical Journal*, 342, d2613.
- Scott, K. D., Gilliam, A., & Braxton, K. (2005). Culturally competent HIV prevention strategies for women of color in the United States. *Health Care for Women International*, 26, 17–45.
- Shedlin, M., & Amastae, J. (2011). Knowledge & beliefs about reproductive anatomy and physiology among Mexican-Origin women in the U.S.: Implications for effective oral contraceptive use. Paper presented at the Annual Meeting of the Population Association of America, Washington, DC.
- Strebel, A., Crawford, M., Shefer, T., Cloete, A., Henda, N., Kaufman, M., et al. (2006). Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. *Journal of Social Aspects of HIV/AIDS*, 3, 516–528.
- Traube, D. E., Holloway, I. W., & Smith, L. (2011). Theory development for HIV behavioral health: Empirical validation of behavior health models specific to HIV risk. *AIDS Care*, 6, 663–670.
- U.S. Centers for Disease Control and Prevention (CDC). (1992a). *Centers for Disease Control HIV/AIDS Surveillance Report*. (pp. 1–22). Bethesda, MD: Author.
- U.S. Centers for Disease Control and Prevention (CDC). (1992b). 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *MMWR*, 41, 1–19.
- U.S. Centers for Disease Control and Prevention (CDC). (1995). *HIV/AIDS surveillance report*. (pp. 1–38). Bethesda, MD: Author.
- U.S. Centers for Disease Control and Prevention (CDC). (2010). *Sexually Transmitted Disease Surveillance 2009*. Atlanta: U.S. Department of Health and Human Services.
- U.S. Centers for Disease Control and Prevention (CDC). (2011). HIV Surveillance in women, slide set. Available: <http://www.cdc.gov>.
- U.S. Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics. (1997, June 12). *Monthly vital statistics report, report of final mortality statistics, 1995*. 45. Bethesda, MD: Author.
- U.S. Centers for Disease Control and Prevention (CDC)/ National Center for Health Statistics. (2001). *National Vital Statistics System. Mortality, 49(11)*. Bethesda, MD: Author.
- Weinman, J., Yusuf, G., Berks, R., Rayner, S., & Petrie, K. J. (2009). How accurate is patients' anatomical knowledge: A cross-sectional, questionnaire study of six patient groups and a general public sample. *BMC Family Practice*, 10, 43.
- Weir, B., Bard, R., O'Brien, K., Casciato, C., & Stark, M. (2007). Uncovering patterns of HIV risk through multiple housing measures. *AIDS and Behavior*, 11(Suppl.), 31–44.
- Wenzel, S., Tucker, J., Elliott, M., & Hambarsoomians, K. (2007). Sexual risk among impoverished women: Understanding the role of housing status. *AIDS and Behavior*, 11(Suppl.), 9–20.
- Williams, D. R. (2005). The health of U.S. racial and ethnic populations. *Journal of Gerontology Series B*, 60, S53–S62.
- Williams, D. R., Allen, S., & Padian, N. (2008). NIMH Multisite HIV/STIs Prevention Trial for African-American Couples. *Journal of Acquired Immune Deficiency Syndromes*, 49(Suppl. 1).
- Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32, 20–47.
- Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences*, 1186, 69–101.
- Wilson, H. W., & Widom, C. S. (2011). Pathways from childhood abuse and neglect to HIV-risk sexual behavior in middle adulthood. *Journal of Consulting and Clinical Psychology*, 79, 236–246.
- Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior*, 27, 539–565.
- World Health Organization. (1992). *Current and future dimensions of the HIV/AIDS pandemic: A capsule summary*. Geneva: Author.
- Wyatt, G. E. (1997). *Stolen women: Reclaiming our sexuality, taking back our lives*. Hoboken, NJ: John Wiley and Sons, Inc.
- Wyatt, G. E., Myers, H. F., & Loeb, T. B. (2004). Women, trauma, and HIV: An overview. *AIDS Behavior*, 8, 401–403.
- Wyatt, G. E., Williams, J. K., & Myers, H. F. (2008). African-American sexuality and HIV/AIDS: Recommendations for future research. *Journal of the National Medical Association*, 100, 44–48, 50–51.
- Zierler, S., & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health*, 18, 401–436.

Author Descriptions

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