Ann O'Leary · Paula M. Frew *Editors*

Poverty in the United States

Women's Voices

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Foreword

I am honored to introduce *Poverty in the United States: Women's Voices* written by strong and committed HIV Prevention Trial Network investigators and coedited by Drs. Ann O'Leary and Paula M. Frew. The editors are two scholars who have dedicated their scientific journeys to advocating for the needs of women and for the design and implementation of scientifically based multilevel interventions for women in the USA and globally. If you have followed Drs. O'Leary and Frew's research as I have, you will not be surprised to learn that they have produced this unique book. *Poverty in the United States: Women's Voices* has a powerful message that although numerous biomedical and behavioral prevention and treatment approaches have been used to slow the public health crises of AIDS, without addressing poverty and food insecurity, which constitute the major drivers of HIV among women, we will not witness the end of AIDS or other public health epidemics in our country.

This book arose from an HIV-focused study whose investigators wished to contextualize the study's HIV incidence findings. One out of five new HIV infections in the USA is among women, and women of color, particularly African American women, are disproportionately affected by HIV. Unfortunately, how the social structural forces of poverty that have shaped the HIV epidemic and other health problems among women of color has been understudied. These women represent the most marginalized segments of our society in terms of economic strength, political force, social status, and access to legal systems.

While most individuals in the USA have met or learned about someone who has suffered from hunger and poverty, few of us acknowledge that this is happening in the wealthiest nation in the world. We think that hunger and poverty occurs primarily in underdeveloped countries. The reality is that the latest Census Income, Poverty, and Health Insurance Data released in September 2015 show that in 2014 about 46.7 million Americans (15.0 %) lived below the poverty line ($24,250 for a family of four in 2014). Women in America are 32 % more likely to be poor than men. Employed women are more likely to be poor than employed men, and women are more likely to be poor at every level of educational attainment than men. African Americans have been found to have the highest poverty rate. African Americans are

disproportionately affected by poverty, food insecurity, and unemployment and are also more likely to receive food assistance than any other ethnic group in the USA. Women make up over 90 % of adult Temporary Assistance to Needy Families (TANF) recipients. Moreover, TANF, the country's main cash assistance program, does not provide sufficient support to prevent hunger, homelessness, and substandard living conditions, such as living with utility cut-offs. Unfortunately, the anti-poverty and safety net programs in the USA have eroded over the past two decades and continue to neglect providing sufficient provisions for helping women and their families escape poverty. Women face not only poverty but also the circumstances that cause them to remain mired in it. They cannot break the cycle of poverty despite their formidable reservoirs of resilience.

Poverty in the United States: Women's Voices is a timely book and one that is urgently needed. A growing number of calls to action have called for addressing structural and policy drivers, such as poverty and food insecurity, in preventing and treating the spread of HIV among women most at risk for infection who live in inner city and rural communities in the USA that have high poverty and extremely high rates of HIV.

One of the novel contributions of this book is the use of qualitative methods to capture the life experiences of such women and how poverty, food insecurity, limited educational opportunities, class, unemployment, policing, incarceration and criminal justice involvement, and community violence have shaped the HIV epidemic in this population. Each of these social structural drivers has, unfortunately, been ignored in the fight against AIDS and other diseases faced by women in the USA. This book is characterized by its rigorous research methods, strong science, and the collective voices it captures that underscore the need for changes to be made in our HIV prevention and treatment interventions and policies.

Poverty in the United States: Women's Voices makes clear that solutions must avoid individually oriented paradigms to resolve the AIDS crisis. Each chapter has integrated science and advocacy strategies to provide the reader with steps that need to be taken to enact large-scale societal changes to end poverty co-occurring issues.

The book forcefully argues how social and political drivers of diseases such as HIV, drug use, mental illness, and gender-based and gun violence will remain with us for many years to come, if social and structural drivers are not addressed. One must not focus on "blaming the victim" ideologies, but on ideologies and approaches that target structural drivers of diseases and social problems which are affecting a large number of women across the USA.

I couldn't agree more with the core underlying messages of the book that posit maintaining the status quo of huge and growing economic and attendant disparities that have befallen the USA over the past decades which have disproportionately affected women is fueling a public health crisis and creating an enormous risk to our nation. The book underscores that public health can be traced to the impact of poverty and social inequities and cannot be stopped with solutions that do not address the original drivers of the problems.

I urge you to read this powerful book to understand women's lives and struggles. This book will be an eye opening experience for many.

The book presents insights, suggestions for innovative and strategic policy reform, such as approaches for expanding reproductive health care, as well as primary health care in general and sexually transmitted diseases and HIV in particular. Women need to get the services they deserve. It also addresses that access to care must be guided by rights-based ideology, where social and economic rights are obtained through government commitment and public policies.

Finally, when you complete reading this book, you will not only have learned about the scope of poverty and its consequences among some of the most vulnerable populations in our society, but also have deepened your understanding about the role of poverty and food insecurity and other drivers of health and social problems. No disease can be reduced or eliminated without addressing these structural drivers.

This book is important for researchers, policy makers, advocates, and service providers. Collectively, the authors make it very clear that women who are poor are not responsible for the conditions and diseases they experience on a daily basis. The book highlights the message that the poor are not responsible for their own fates and systematically demonstrates how this belief is a major obstacle to economic redistribution, the creation of services and "safety nets" that are essential for reducing health disparities and achieving the end game of lifting women out of poverty. Each of us needs to have a better grasp of the many sorrows and stresses that poverty manifests in the daily lives of poor women who are often challenged with intersections of other marginal identities, gender and race most specifically.

This book serves as a way to engage with the life experiences of those who are often left voiceless, hearing both their traumas and their successes and resiliency. The book sends a message to politicians and policy makers to avoid blaming the women who are victims of life's poor conditions. This valuable book sends the message to people who have little experience with poverty and may not realize the degree to which Americans suffer hunger, violence, addiction, community, and gun violence.

This book calls for the reader to look for and embrace points of transformation in the systems which facilitate the attitudes, narratives, and policies that fuel the conditions of poverty.

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Preface

The tendency to attribute blame to the unfortunate is very common in the case of people living in poverty (Cozzarelli, Wilkinson, & Tagler, 2001; Rice, 2015). Historically, economic status was perceived by many to be reflective of the individual's ability and industry, and many still believe this to be true. Others believe poverty to be caused by economic unfairness and discrimination. In editing this book, we were aware of the possibility that readers might take much of the content—substance use, unemployment, and violence—to be indicative that the poor participants in our study were in some way responsible for their plight. In an effort to contextualize these topics in the chapters, we asked authors to start each chapter with a sociohistorical description of how current conditions came to be and to end with a section on policy recommendations.

One personal factor that has been studied as a contributor to people's tendencies to attribute blame to the unfortunate generally and the poor specifically is the "just world" hypothesis (Lerner, 1970). This refers to the belief that the world is just and people get what they deserve. It is a specific example of the "fundamental attribution error" marked by a tendency to attribute one's own fate to external factors and those of others to internal traits (Ross, 1977). This belief system is believed to be motivated by fear that the person themselves may fall prey to the same misfortune if causes are seen as being random or systemically caused (as US poverty, by and large, is). The notion that people are responsible for their own fates is a major impediment to economic redistribution and the creation of services and "safety nets" for the disadvantaged (Lane, 2001).

A substantial body of research has documented people's tendencies to apply the just world hypothesis to victims of misfortune. These include victims of sexual assault (Patel, 2009), economic inequality following Hurricane Katrina (Belle, 2006), as well as poverty (Cozzarelli et al., 2001; Shapiro, 2003). Further, individuals who believe in a just world have been shown to have more negative attitudes toward poverty and the poor (Shapiro, 2003). Interventions have been developed that attempt to reduce these attitudes (Ioannou, Kouta, & Andreou, 2015).

These attitudes however are not, in and of themselves, a slight on the character of those who believe them; in fact, they are emblematic of the challenges of living in a diverse nation, a nation where, in order to achieve equity for all citizens, we can have no room for assumptions about the lived experiences and the status of the well-being of others. It is about competence, not character. Many Americans will never be given the opportunity to understand the crippling angst and stress that poverty manifests in the daily lives of the impoverished. Moreover, socioeconomic status is oftentimes further complicated at the intersections of other marginal identities, gender, and race most specifically. Complicated by our nation's challenges with knowledgably engaging in and navigating racial and gendered dynamics is a racial and gendered illiteracy (Stevenson, 2013). It is at these identity intersections that we can see the synergy of multiple levels of systemic oppression and insufficient public policy, policy which orients itself toward a capitalist brand of efficiency rather than a politic of humanity.

In twenty-first century America, from gentrification to water contamination and discrimination to congressional obstruction, the poor are often the victims of displacement, insecurity, and state-sponsored violence at all levels. These factors create a perfect storm of isolation and stress which is neatly tucked away from the American consciousness. This text should serve as a way to engage the narratives of those who are often left voiceless, hearing both their traumas and their triumphs. Acknowledging the resilience of their humanity and spirit despite their conditions will be instrumental in order to develop a desire to understand further the lives lived by those who are in poverty.

In the face of tragic events, "conspiracy theories" are often voiced. However, sometimes conspiracy theories have truth to them. For example, many people believe that crack cocaine—a drug that decimated inner cities in the late 1980s and early 1990s—was intentionally distributed within inner cities (where it still exists today). Cheap and highly addicting, this form of cocaine was associated with extreme behavior (for extensive descriptions of the lifestyles of women who were addicted to crack, see Sharpe, 2005; Sterk, 1999). In fact, an investigation by the U.S. Department of Justice revealed that the anti-Sandinista Contras had been smuggling crack cocaine from Central America into the Los Angeles area and returned the cash profits to pay for automatic weapons. While the role of the CIA (Central Intelligence Agency) in this situation remains controversial, the explosion of crack cocaine in the urban USA is believed to have been sparked by this process (U.S. Department of Justice, 1997).

It is our hope that this book will have the effect of preventing blaming of the victims described here by increasing awareness of the life conditions experienced by many poor women and that they will come to life for readers with their verbatim quotes. We hope that the book will be read by people who have little experience with poverty and may not realize the degree to which Americans suffer hunger, violence, addiction, and other factors that are topics of these chapters. We hope that educating the public in this way about the suffering caused by poverty will increase empathy and with it the desire to reform harmful policies and practices.

Beyond the narratives shared in this volume, developing this empathy will require that readers look both reflexively and introspectively at the conditions of poverty in relation to their own lives. For many, especially those who have little personal experience with poverty, it is very easy and quite compelling to overestimate the validity the assumptions made about opportunity, access, and ability in America. Despite this ease, we cannot neglect the emotional and psychological ramifications of poverty, wounds that can never truly be healed. We encourage our readers to probe more deeply, beyond "bootstrap" and "American Dream" narratives. We ask you to stand face to face with the historical and contemporary realities of our nation surrounding the dehumanization of our fellow citizens in our quest for wealth and power. We encourage our readers to vicariously engage with the trauma of intergenerational social exclusion, systemic inequity, and status quo deficitization that has shaped life trajectories of the poor and the common perspectives many have of their conditions.

Moreover, developing this empathy will require that readers confront the concrete realities of the vast racial, ethnic, and socioeconomic disparities in the domains of health, education, justice, and employment that affect the lived experiences of those who live in poverty. By taking a systemic and life course view of poverty, we can see that poverty is not a moment in time but is being shaped and made at all times, shaped and made by failing schools with underqualified teachers, schools which prioritize neoliberal labor-market educational aims over the concerted preparation of students to thrive in an ever-changing world. The same schools contribute most egregiously to the school to prison pipeline and school-related trauma (Nasir, 2011). Poverty results from being embedded in communities where over-policing and over-incarceration tear apart households and limits family earning potential (Alexander, 2012). It affects both the psychological and corporal experience of those in its grasp at every moment of every day.

We encourage our readers to endeavor to question their own assumptions about the nature of American life, survival, and opportunity. Are the conditions as they seem? If not, how can we even begin to blame the victim? Napier, Mandisodza, Andersen, and Jost (2006), in their analysis of reactions to the victims of Hurricane Katrina, invite us to consider where and why we attribute blame for issues which are at their root systemic. The authors note that in the wake of one of the most devastating environmental disasters of the twenty-first century, people blamed the victims of the hurricane, despite the many failures of the local and national government to respond adequately to the warnings. Ask yourself what role these "victim-blaming attributions" (p. 64) play for us psychologically and emotionally? Do we engage them as a way to cope in an inequitable world? Do we lean on them to avoid grappling with the reality of our nation's multisystemic challenges? How do we consider the role of systems and institutions in constructing and maintaining systems of poverty? These are the questions we must wrestle with. In this spirit, we also challenge our readers to look for sites of transformation in the systems which facilitate the attitudes, narratives, and policies that facilitate the conditions of poverty. It is at these sites that we will find possibility for transformation, the impetus for rehumanization, and paths out of poverty.

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Disclaimer

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Ann O'Leary is a psychologist living in Atlanta, Georgia. She served as a senior behavioral scientist in the Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, for 16 years. Her training included a summa cum laude undergraduate degree from the University of Pennsylvania; a Ph.D. in Psychology from Stanford University, supported by a National Science Foundation fellowship; and 1 year of postdoctoral training in Health Psychology at the University of California at San Francisco. She served on the faculty of the Psychology Department at Rutgers University from 1986 to 1999. She has conducted research on HIV prevention for the past 26 years and has also published many articles on other aspects of Health Psychology. Dr. O'Leary has published more than 165 scientific articles and chapters and has edited or coedited five books, *Women at Risk: Issues in the Primary Prevention of AIDS*; *Women and AIDS: Coping and Care*; *Beyond Condoms: Alternative Approaches to HIV Prevention*; *From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention*; and *African Americans and HIV/AIDS: Understanding and Addressing the Epidemic.* She is a fellow of the American Psychological Association and won the inaugural "Distinguished Leader" award from the APA's Committee on Psychology and AIDS. She serves on the editorial boards of several scientific journals and is a frequent consultant to the NIH and other scientific organizations.

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Chapter 1
Women and Poverty in the USA

Sally Hodder, H. Spiegel, Lydia Soto-Torres, and Danielle F. Haley

Introduction

Since 1981, more than 36.9 million people globally have been infected with human immunodeficiency virus (HIV), including more than 1.2 million who have died (World Health Organization, 2016). Though it was known early in the HIV epidemic that consistent condom use prevented sexual transmission of HIV infection and highly active antiretroviral therapy has been accessible in the USA for more than 15 years, new HIV infections have been relatively stable over the past decade. The HIV Prevention Trials Network (HPTN) has conducted cutting-edge HIV prevention studies across the globe. In an effort to address HIV prevention among US women, the HPTN 064 Women's HIV Seroincidence Study was designed to assess HIV incidence among women in the USA most likely to be at risk for HIV acquisition. The HPTN 064 investigators were struck by the ubiquitous, substantive theme of poverty in the lives of women participating in the 064 study. Poverty among US women is a compelling concern that policy makers, citizens, and students of social science, politics, justice, and health outcomes need to understand. We now bring a snapshot of poverty's impact on the lives of women in the USA, in their own words.

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The purpose of this introductory chapter is to provide an overview of poverty among US women, describe current epidemiology of HIV among US women, and summarize the rationale, study design, and results of the HPTN 064 study.

Description of Poverty Among US Women

Forty-six million persons in the USA were living in poverty in 2012, more than in the previous 54 years (National Center for Law and Economic Justice, 2007–2015). In 2013, the median household income in the USA was $51,939 (U.S. Census Bureau, 2014). Though median US income in 2013 was not significantly different from that in 2012, real median household income in 2013 was 8 % lower than that in 2007, a time point before the recent recession (U.S. Census Bureau, 2014). Critical to any discussion of poverty in the USA is an understanding of the vastly uneven distribution of income. US households in the lowest quintile had annual incomes of $20,901 or less while the highest quintile had incomes of greater than $105,910. Moreover, households in the top 5 % had incomes of more than $196,000.

Poverty is not an unbiased condition. More women than men live in poverty. Among persons aged 18–64 years, 15 % of women and 11.8 % of men live in poverty; this difference is amplified in the older age group (>64 years) where 11.6 % of women compared with 6.8 % of men live in poverty. Thirty-one percent of households headed by a single woman lived in poverty compared with 16.4 % of single male-headed households and 6.3 % of households led by married couples (National Center for Law and Economic Justice, 2015). Relevant to working persons, women have an earnings ratio of 0.78 compared with men, a ratio that has not significantly increased for the past 6 years, providing a pathetic commentary on economic inequality of the sexes in the USA.

Nearly 20 million persons in the USA live in deep poverty, defined by household incomes below 50 % of the poverty line (U.S. Census Bureau, 2014). More than twice as many black persons (12.2 %) compared with white persons (5.3 %) and more women (6.9 %) than men (5.7 %) live in deep poverty (U.S. Census Bureau, 2014).

Epidemiology of HIV Among US Women

Historically, HIV infection in the USA has been most common among men who have sex with men. Cases of AIDS among women (as a proportion of all US AIDS cases) increased from approximately 7 % in 1985 to 25 % in 2011 (Centers for Disease Control and Prevention, 2012a). Today, women constitute approximately 20 % of individuals with newly diagnosed HIV infections in the USA (Centers for Disease Control and Prevention, 2012a). Most HIV infection in women is acquired through heterosexual contact, with 89 % of cases among black women and 75 % of cases in white women attributed to heterosexual contact (Centers for Disease Control and Prevention, 2012a, 2012b). Surveillance data demonstrate that 64 % of newly diagnosed HIV infections

among US women occur among black women and 18 % among white women (Centers for Disease Control and Prevention, 2014). As black women constitute approximately 13 % of the US female population (U.S. Census Bureau, 2014), there is a marked disparity in infection rates of black compared with white women. Unfortunately, the disparity does not stop with infection rates; black women have a significantly higher risk of progression to AIDS and death (Centers for Disease Control and Prevention, 2012a).

Poverty and HIV are closely associated in the USA. In a cross-sectional study of 18,430 heterosexual participants aged 18–50 years conducted in 2006–2007 by the Centers for Disease Control and Prevention (CDC), 49 % lived in poverty. The HIV prevalence among those participants living in poverty was 2.1 %, 20 times greater than the HIV prevalence among all US heterosexuals. Moreover, HIV prevalence was 2.8 % among those with a household income less than $10,000 compared with 0.4 % for those with a household income ≥$50,000 (Denning & DiNenno, 2010).

Summary of HPTN 064

Rationale for Study

In 2008, scant HIV incidence data for US women existed, limiting the ability to design robust domestic HIV prevention trials. Therefore, before trials assessing the efficacy of any HIV prevention interventions for US women could be designed, accurate HIV incidence data were needed. To evaluate HIV incidence among US women living in geographic areas with high rates of poverty and HIV prevalence and to assess factors that may increase their risk for HIV acquisition and other health problems, the HPTN supported design and conduct of the 064 study, the Women's HIV Seroincidence Study. HPTN 064 was intended to provide better understanding of the risk of HIV infection among certain populations of US women and to provide information about risk behaviors. A qualitative substudy conducted at four of the ten HPTN 064 study sites assessed social, structural, and other contextual factors likely to affect women's sexual and other risk-related decision making as well as women's preferred recruitment and retention strategies for future studies.

Study Design

HPTN 064 was a multisite, longitudinal cohort study conducted in 2009–2011 in ten urban and periurban communities in six geographic areas of the USA (Atlanta, GA; Baltimore, MD; New York, NY; Newark, NJ; Raleigh/Durham, NC; Washington, D.C.). The study was approved by institutional review boards at each of the study sites.

Eligible individuals were 18–44 years of age, self-identified as a woman (transwomen were eligible), reported at least one episode of unprotected vaginal and/or anal sex with a man in the 6 months before enrollment, and were willing to undergo

HIV rapid testing. Additional inclusion criteria were that individuals reside in census tracts (zip codes for the Bronx and Harlem) that ranked in the top 30th percentile of HIV prevalence and with >25 % of inhabitants living below the US federal poverty line. Eligible individuals also had to report ≥1 of the following in past 6 months: (a) illicit injection and/or non-injection drug use (e.g., heroin, cocaine, crack cocaine, methamphetamine, and/or use of prescription drugs apart from those prescribed by a licensed provider); (b) alcohol dependence (defined as CAGE Score ≥2), (Ewing, 1984); (c) binge drinking, defined as ≥4 drinks at one time by a woman; (d) self-reported history of sexually transmitted infections (STIs) (gonorrhea, chlamydia, or syphilis); (e) exchange of sex for commodities (e.g., drugs, money, shelter); (f) incarceration (jail and/or prison ≥24 h within past 5 years); and (g) reported male sexual partner with reported history of incarceration (within past 5 years), injection or non-injection drug use, STIs, HIV diagnosis, history of binge drinking (≥5 drinks at one time by a man), and/or alcohol dependence (CAGE Score ≥2) (Ewing, 1984).

Exclusion criteria included self-reported history of a previous positive HIV test, current HIV prevention trial enrollment, current/past participation in an HIV vaccine trial, or anticipated absence for >2 consecutive months during the follow-up period.

Recruitment and Study Procedures

Venue-based recruitment using time-space sampling, a method used successfully in previous studies to obtain large, diverse samples among hard-to-reach populations (MacKellar, Valleroy, Karon, Lemp, & Janssen, 1996; Muhib et al., 2001; Stueve, O'Donnell, Duran, San Doval, & Blome, 2001), was conducted in an effort to sample women that may not have been reached using other standard recruitment methodologies. Specific venues (or locations) in which young women from the target census tracts (or zip codes) could reasonably be expected to congregate were identified and a list of potential venues (e.g., laundromats, street corners, liquor stores) was created by each study site. Venues were then evaluated by study personnel as to whether the target population (i.e., women likely to meet eligibility criteria) frequented the location and at what hours. Venues frequented by few women between 18 and 44 years of age were eliminated. In addition, feasibility of venues as appropriate recruitment locations was assessed and inappropriate venues (e.g., those frequented predominantly by women aged outside the 18–44 range or by men, where confidentiality or safety were a concern, or where study staff were barred from accessing venue attendees by owners) were eliminated from the final venue list (Haley et al., 2014). Venues for specified time periods were randomly selected each month in order to construct a sampling event calendar. To minimize selection bias, women present at a designated venue were systematically approached for prescreening when they entered a predetermined "recruitment area" (e.g., study staff designated the exact space that a potential subject must first enter before she was

approached and asked about possible study participation). Women giving verbal approval for prescreening were asked a limited number of eligibility questions in a more private area within the recruitment venue (e.g., outside direct line of foot traffic). Women who met eligibility criteria and provided written consent to participate in the HPTN 064 study were subsequently enrolled in an area that provided additional privacy (i.e., the clinical research site, mobile van, or private room at venue). Enrolled participants were compensated for their time and transportation.

Participants received HIV rapid testing and audio computer-assisted self-interview (ACASI)-delivered surveys at baseline and at 6-month intervals for up to 12 months. The ACASI included questions regarding socioeconomic factors, food insecurity, mental health (depression and post-traumatic stress disorder (PTSD)), sexual behavior, history of STIs, domestic violence, health perceptions, and social support.

Determination of HIV Incidence

The primary outcome of the study was a composite measure of HIV incidence that included infections acquired shortly before enrollment (recent infections), acute infections detected at study entry, and seroconversion events that occurred during study follow-up. Acute HIV infections were detected using a fourth-generation antigen/antibody assay and/or an HIV RNA test (Laeyendecker et al., 2013). Recent HIV infection was assessed at study entry using a multi-assay algorithm (Laeyendecker et al., 2013) which includes the CD4 cell count, HIV RNA viral load, the BED capture immunoassay (BED-CEIA), measuring the proportion of IgG that is HIV specific (Hall et al., 2008), and an assay that measures the avidity of anti-HIVantibodies for target antigens (Masciotra et al., 2010). HIV seroconversion during follow-up was assessed using HIV rapid test screening with Western blot confirmation. HIV incidence findings from all communities were pooled, as per a priori plans.

Qualitative Substudy

The qualitative substudy was conducted at four study sites: Raleigh/Durham, Washington, D.C., the Bronx, and Atlanta. Semi-structured interviews were conducted with 130 women for purposes of identifying social, structural, and other contextual factors likely to affect women's sexual and other risk-related decision making. Additionally, 31 focus groups were held consisting of women of similar age, race, and ethnicity to discuss barriers to HIV prevention. Women participated in either the interviews or the focus groups (ineligible to participate in both activities). The rich dialogue of both the interviews and focus groups provided the basis for the theme-based content of this book.