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Addressing the Inequality Epidemic: Applying a Structural Approach to Social Work Practice with People Affected by HIV/AIDS in the United States

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Abstract

Globally, HIV risk and the health of HIV positive people are linked with structural inequalities, such as poverty, racism, and homophobia. This article summarizes key features of the structural approach to social work practice and applies the perspective to working with people affected by HIV/AIDS in the United States. Structural factors influencing HIV risk and health include housing, an individual-level factor; health care access, a community-level factor; and homophobia, a societal-level factor. Structural inequalities at each level are critical to understanding the context of HIV risk and should be assessed and addressed in social work practice in the field of HIV/AIDS.

KEYWORDS: critical theory, HIV/AIDS, inequality, oppression, structural social work

Introduction

Researchers, advocates, and practitioners alike recognize that the global HIV/AIDS epidemic is linked with structural inequalities and oppression (Amon & Kasambala, 2009; Poindexter, 2009; Rotheram-Borus, Swendeman, & Chovnick, 2009). All of the groups most strongly impacted by HIV/AIDS are already marginalized in other ways in nearly all societies (Mill, Edwards, Jackson, MacLean, & Chaw-Kant, 2010). In the United States, HIV prevalence is overwhelmingly disproportional in low-income people, people of color, and gay men. HIV prevalence rates in the U.S. are highest in areas of concentrated urban poverty (Denning & DiNenno, 2010), and the racialized nature of epidemic is undeniable. African Americans, who are 13% of the U.S. population, comprised 40% of AIDS cases and 37% of AIDS-related deaths

through 2003 (Centers for Disease Control and Prevention [CDC], 2005). Among men who have sex with men, the risk group that accounts for the majority of new and current HIV infections in the U.S., black and Latino men are the most vulnerable in terms of contracting HIV and AIDS-related mortality (CDC, 2010; Peterson & Jones, 2009).

Despite the close entanglement of structural inequalities including poverty, racism, and homophobia with the HIV/AIDS epidemic, prevention work has focused largely on behavior change and risk reduction strategies at the individual level, which have often failed to take the context of structural inequality into account (Sumartojo, 2000; Wohlfeiler, 2002). This is consistent with the social work profession's longstanding emphasis on individual rehabilitation, reform, and repair, which has occurred in spite of professed commitment to social justice and social change (Specht & Courtney, 1994). The structural model of social work practice presents an alternative perspective. Rooted in radical, feminist, and anti-oppressive theory, structural social work is concerned with the ideologies and institutions that contribute to the problems and experiences of individuals (Allan, 2003a; Moreau, 1979; Mullaly, 2007). In contrast to most ecological approaches, the emphasis in structural social work is not on maximizing fit between person and environment, but rather on changing aspects of the environment at proximate and societal levels toward a more equal distribution of power and resources (Pease, 2003).

The unyieldingly high rate of new HIV infections occurring in the U.S.—about 56,000 each year—has led many researchers to conclude that individual-level approaches alone will not be adequate in halting the epidemic (CDC, 2010; Rotheram-Borus et al., 2009). The structural approach offers insight into how social workers can work with service users, community members, and professionals from other fields to affect change in the structures that shape the environments in which HIV-related health and risk behaviors take place. This analysis provides a brief overview of the structural approach to social work practice, which, though commonly taught in Canadian and Australian schools of social work, is less familiar to most American social workers (Cabrera, 2009). Following this overview is a discussion of how the structural approach can be applied to social work practice with people affected by HIV/AIDS, illustrated with a case study.

Overview of Structural Social Work

Structural social work is not a specific theory or practice modality, but an approach to practice that draws from several theoretical bases and articulates the usage of core social work practices in distinct and radical ways. Using Meyer's (1983) framework for analyzing practice approaches, this overview highlights several key elements of structural practice, including historical context, problem and goal definition, use of the professional relationship, and associated practices.

Definition and Brief History

The term “structural social work” emerged in the literature in the 1970s. Though first used by Middleman and Goldberg (1974), Moreau's 1979 *Canadian Journal of Social Work Education* article, “A Structural Approach to Social Work,” is widely recognized as the beginning of structural social work scholarship. In this article, Moreau succinctly describes

structural social work as “concerned with the ways in which the rich and powerful in society define and constrain the poor and the less powerful” (p. 78).

Structural social work focuses on linking people’s personal problems to the inequalities inherent in dominant ideologies, including capitalism, providing a framework for practice in which social workers help service users access resources to meet their immediate needs while also working to transform the root social, economic, and political causes of oppression. In the current edition of the landmark structural text *The New Structural Social Work*, Mullaly (2007) advances a definition of structural social work that is *descriptive* in its emphasis on locating the structural determinants of the problems that social workers and their clients face; *prescriptive* in that it requires social work action to be directed not only at individuals, but also at systems and society; and *inclusive* in that it is not limited to any one form or method of social work practice (i.e. individual, group, and community) and recognizes all forms of oppression (p. 210-211, emphasis added).

Structural social work has been informed by the larger body of critical social work theory, including radical, feminist, and anti-oppressive perspectives. Radical social work perspectives rooted in Marxist theories, such as Galper (1975), have been critical of the social control aspects of the social work profession and call for collective action to share wealth and resources and meet human need (Martin, 2003). Feminist, anti-oppressive, and anti-racist social work theories have developed and expanded in recent decades, emphasizing the ways in which power and oppression are tied not only to class but also to constructs such as race, gender, age, and sexual orientation (Mullaly, 2007). Feminist and anti-oppressive theories advance the idea that “the personal is political,” an important concept in structural social work linking personal experiences with transformative political action (Dominelli, 2008; Fook, 1993; Mullaly, 2007). Theory is of course not static, and the development of diverse perspectives within radical, feminist, and anti-oppressive discourse continues to shape the structural approach.

Problem and Goal Definition

A structural social work perspective can be applied at individual, family, group, or community levels. At each level, this approach emphasizes placing problems or issues in a structural context. Social workers engage service users in a process of ideological analysis, examining how dominant ideologies may be contributing to the problems people experience (Fook, 1993). For example, problem definition might include discussing how the dominant ideologies of patriarchy and capitalism contribute to feelings of depression and hopelessness for a disabled man who is unable to work. This process includes exploring the extent to which the service user, group, or community has internalized dominant ideologies. Additionally, problem definition involves analysis of how socioeconomic institutions and structures contribute to the problem, such as how drug policies and incarceration rates have affected African American communities in the U.S.

One criticism of structural social work, and critical social work in general, is that it shifts blame for individual troubles to the environment or the system, absolving people of personal responsibility (Payne, 2005). Mullaly (2007) responds that while the structural approach represents a distinct shift from other approaches that focus too strongly on individual pathology,

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it does not simply replace a “blaming the victim” mentality with “blaming the system.” While systemic oppression is not an excuse for individual harmful behavior, such as drug use, it is often a partial explanation of or contributor to behavior. Thus, the approach recognizes the need for social workers to address harmful behaviors while not overly pathologizing service users for them.

Use of the Professional Relationship

A hallmark of structural social work is that professional relationships between social workers and service users are centered on dialogue, collaboration, and power sharing. Moreau (1979) describes such relationships as dialogical, marked by “horizontal exchange rather than vertical imposition” (p. 89). To facilitate such exchanges and power sharing, the social worker deemphasizes his or her professional knowledge and expertise, while regarding the service user as an expert on his or her life and experiences (Allan, 2003a; Mullaly, 2007). Thus, both bring unique skills and perspectives to the relationship.

Another key aspect of power sharing is the demystification of social work activities (Moreau, 1979). From a structural approach, social workers should avoid using professional jargon and should be clear about their skills and methods, working collaboratively with service users instead of treating them as passive subjects. Hence, the terminology of structural social work frequently employs the term “service user” instead of “client” to connote equality and collaboration in the relationship. Simply using the words “people” or “citizens” are further alternatives that avoid the negative connotations of having client or patient status (Ife, 2001, p. 169). The word “intervention,” which implies that the social worker is an outside expert and the service user is a passive recipient of the social worker’s expertise, is avoided in most current structural literature, replaced by broader terms such as “work” and “practice” (Allan, 2003b; Ife, 2001).

Structural Social Work Practices

Structural social work is not reserved for macro or community practice. Practice approaches used to work with individuals, families, and groups in structural social work include fostering critical consciousness, empowerment strategies, facilitating access to resources, and promoting group work and collectivization. While these approaches are not unique to structural social work, structural practice is marked by using core skills with radical or transformative intent (Pease & Fook, 1999).

Critical consciousness. Originating in Freire’s (1970) conscientization approach to education, the concept of critical consciousness has been further developed in anti-oppressive, structural, and other critical theories (Sakamoto & Pitner, 2005). The connection between reflection and action is at the core of critical consciousness. Through reflection, people come to see connections between their situations and the structures and dominant ideologies that contribute to them. Fook (1993) describes a technique of critical questioning, based in feminist therapy, to help service users assess their assumptions and beliefs, which are often linked to internalized oppression. For example, Fook suggests asking a woman who is reflecting on her family and career choices, “Is that what you think, or what you think is expected of you?” (p.

98). Since critical consciousness is an active process, it does not end with reflection and empathic exchange, but includes action toward addressing oppression and social justice (Sakamoto & Pitner, 2005).

Empowerment strategies. In structural social work, empowerment does not mean social workers giving or lending power to service users, but rather service users empowering themselves to exercise greater control, choice, and action in their lives. Like critical consciousness, it is a process as well as an outcome (Allan, 2003b). Empowerment can take place at personal, organizational, cultural, and societal levels. Some of the other approaches described in this section, including facilitating critical consciousness and assisting service users in forming mutual aid networks, are ways of helping service users realize and act on their power. Fook (1993) writes of “giving clients powerful experiences,” essentially providing service users with opportunities to demonstrate more power and choice than they ordinarily have (p. 102). Examples include helping youth become involved in community organizing work or giving a service user the opportunity to teach the worker or others in the community a new skill.

Facilitating access to resources. It is difficult if not nearly impossible for people to work toward structural change when their basic needs are not being met. Therefore, an important aspect of structural social work is connecting people to the resources needed for survival and growth, such as housing, income supports, food, health care, and education. Moreau (1979) articulates that when social workers link service users with resources, they should do so with explicit attention to the assumptions and power dynamics underlying the arrangements, such as if the service or resource is regarded as an entitlement or a privilege, or if there are social control aspects associated with it. This helps service users not to blame themselves when confronted with contradictions in accessing social service, such as when staff interrogate service users or treat them as lazy or irresponsible even when applying for a service to which they are entitled. It also highlights the types of reforms that are needed in service delivery systems.

When formal services are inadequate or nonexistent, social workers can help connect service users with one another to form self-help or mutual aid networks. This reflects a strengths-based assumption that people who have needs also have resources (Wood & Tully, 2006). Carpools and food cooperatives are examples of mutual aid (Fook, 1993). Another outgrowth of mutual aid is the development of alternative service organizations that are led by service users rather than professionals seen as outside experts. Mutual aid and alternative service organizations do not replace formal services or compensate for the inadequacies of the current social welfare system, but rather provide a base from which service users can meet their needs while striving for structural change (Mullaly, 2007).

Group work and collectivization. The structural social work approach prioritizes group over individual modalities of service provision when possible. Group work is an expression of the value of collectivism, a powerful component of socialism and an anecdote to the individualist nature of capitalist society (Mullaly, 2007). Groups of service users can form for multiple reasons, including consciousness raising, mutual aid, advocacy, and political action. The process of critical consciousness may be more powerful when undertaken in groups, where people are likely to have some common experiences with oppression as well as unique experiences and perspectives (Moreau, 1979). Groups of service users are also generally better able to advocate

for change within and against systems than are individuals. Therefore, structural social workers aim to help service users connect with existing groups, connect with one another within agencies or service settings, and amplify the voice of consumer advocacy groups within organizations.

Structural Social Work Practice with People Affected by HIV/AIDS

HIV/AIDS is transmitted almost exclusively through individual risk behaviors, namely unprotected sexual intercourse and sharing needles or other injection equipment. However, structural elements appear to influence individual risk, from proximal factors such as housing (Aidala & Sumartojo, 2007) to broader factors including racism and homophobia (Poindexter, 2009; Sullivan & Wolitski, 2008). These factors influence not only risk, but health and mental health more broadly (Wolitski, Valdiserri, & Stall, 2008). Thus, social workers working with communities and individuals affected by HIV/AIDS may benefit from using a structural approach that focuses attention on the structural contributors to health and risk. This analysis highlights examples of structural influences at three levels: housing, which affects health and risk mainly at the level of individuals and families; health care access, conceptualized here as an organizational or community-level factor; and homophobia, a societal-level influence. While far from exhaustive, these factors provide a sense of the structural context of HIV/AIDS risk.

Housing: An Individual-Level Structural Factor

Housing affects HIV risk behaviors as well as the health of people who are HIV positive. Several studies have documented that people who are homeless or marginally housed have higher HIV prevalence rates, and are more likely to engage in risk behaviors such as needle sharing, unprotected sex, and exchanging sex for money or drugs (Aidala, Cross, Stall, Harre, & Sumartojo, 2005; Corneil et al., 2004; Weir, Bard, O'Brien, Casciato, & Stark, 2007). While researchers are still exploring the reasons for this, some possible explanations for the association between unstable housing and HIV risk include the difficulty injection drug users have in accessing clean syringes while staying on the street or in shelters, the pressure to exchange sex for rent money or a place to sleep, and the pervasive feelings of hopelessness that many homeless people experience (Dickson-Gomez et al., 2009). Homelessness may present particular risks for women, who are generally not well-served by emergency shelters, often designed primarily to accommodate homeless men (Wechsberg et al., 2003).

Additionally, housing is a critical resource for improving the health and well-being of HIV positive people. Comparisons of homeless and stably housed HIV positive individuals have found that stable housing is associated with increased health care utilization, improved medication adherence, and general improvements in physical and mental health (Leaver, Bargh, Dunn, & Hwang, 2007). A recent randomized controlled trial conducted in Chicago, in which homeless people with chronic medical conditions including HIV were randomly assigned to receive subsidized housing and case management or standard discharge planning following a hospital stay, found that stable housing was associated with reduced use of emergency room care and shorter hospital stays (Sadowski, Kee, VanderWeele, & Buchanan, 2009).

Understanding these associations, structural social workers should help service users who are homeless or unstably housed to access housing. This includes applying for housing subsidies

if service users cannot afford housing on their own, with attention to the limitations and conditions inherent in accepting different types of subsidies. “Housing first” programs—which typically provide substance abuse and mental health treatment services alongside subsidized housing, but do not require participation in treatment as a prerequisite for housing—are consistent with a structural approach, in that they reduce barriers to participants accessing an essential resource (Padgett, Gulcur, & Tsemberis, 2006).

Structural social workers can also engage in advocacy to make housing a more accessible and equitable resource in the U.S. This may include encouraging service users to become involved in tenants’ unions to improve housing and neighborhood conditions, and advocating alongside service users for increased funding for subsidized housing and services for all low-income people and HIV positive people in particular. An important prerequisite for this work may be consciousness raising around the structural causes of homelessness, as service providers and service users alike tend to blame individuals for becoming homeless, rather than examining the economic and political factors that contribute to the problem of homelessness (Lyon-Callo, 2000).

Health Care Access: A Community-Level Structural Factor

Having access to health care and prevention services is essential for people who are HIV positive or at high risk of contracting HIV. In the United States, being able to access competent health care is inextricably linked with poverty, racism, and homophobia. At a fundamental level, low-income people, people of color, sexual minorities, and immigrants are less likely to have health insurance, which greatly compromises health care access and is associated with a variety of reduced health outcomes (Butterfield, Rocha, & Butterfield, 2010; Ramchand & Fox, 2008). Several factors contribute to this situation, including employment discrimination against people of color and sexual minorities, and the fact that gay and lesbian people are unable to access partner benefits through marriage in most states. In addition, policies on pre-existing conditions make it difficult for HIV positive people to independently purchase private insurance under the current structure of the U.S. health care system (Ramchand & Fox, 2008).

These barriers have particular implications for HIV/AIDS. One study of HIV positive people found that people of color and people without insurance waited significantly longer to access new antiretroviral therapies, and that specialized HIV clinics were less likely to be found in impoverished minority communities (McKinney & Marconi, 2002). Having access to care does not guarantee that it will be competent. For example, black men who have sex with men (MSM) are more likely than white MSM to report discrimination in healthcare settings (Peterson & Jones, 2009) and transgender people of all races report very high levels of discrimination as well as harassment and violence in medical settings (Grant, Mottet, & Tanis, 2010).

At a basic level, structural social work, like all social work, must start with helping people meet their immediate needs, including health care. Thus, structural social workers should use their advocacy skills to help uninsured people obtain insurance when feasible, such as by providing assistance in navigating the complex bureaucratic maze of applying for Medicaid and prescription drug assistance programs. In addition, social workers should help service users overcome barriers such as transportation and language to access the most competent care

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possible. This may include assisting service users in advocating for themselves with health care providers who demonstrate discriminatory attitudes or behaviors. At a community level, structural social workers can work to bring specialized HIV services to the minority communities that have been disproportionately impacted by HIV/AIDS, yet often lack the services and resources for effective treatment and prevention. Additionally, structural social workers and service users should advocate to reform the U.S. health care system to include universal health care for all.

Homophobia and Heterosexism: Societal-Level Structural Factors

In the United States, MSM comprise the largest HIV risk group, and MSM throughout the world have been disproportionately affected by HIV/AIDS (CDC, 2010; Parker, Khan, & Aggleton, 1998). HIV prevention and gay men's access to treatment and care have been limited by homophobia and heterosexism. Homophobia refers to hostility and negative attitudes about homosexuality, while heterosexism is the privileging of heterosexual norms, behavior, and culture over anything that deviates from this (Herek, Chopp, & Strohl, 2007). Thus, both concepts are rooted in the stigmatizing of sexual minorities (lesbian and bisexual women are also affected by homophobia and heterosexism in manifold ways, but are at a much lower HIV risk than MSM due to different risk behavior profiles). A related concept is transphobia, which is negative attitudes and hostility toward people whose gender identity or presentation differs from their sex as assigned at birth (Lombardi, 2007). Transgender individuals experience a range of health disparities, including devastatingly high HIV prevalence of 16 to 48% in male-to-female transgender women (Lawrence, 2007).

Sexual minority stigma is related to HIV/AIDS risk in several ways. In many countries and in some U.S. states until the 2003 Supreme Court ruling *Lawrence v. Texas*, some sexual acts between men are or recently were illegal (Herek et al., 2007). Criminalizing sex between men forces MSM into secrecy, making it difficult for men to access prevention and HIV testing services, or to disclose their HIV status for fear of harassment, blackmail, and arrest (Beyrer, 2010). Another example of the effects of stigma is employment discrimination against male-to-female transgender women, which is linked to participation in commercial sex work and contributes to the elevated HIV prevalence in this population (Nemoto, Operario, Keatley, & Villegas, 2004).

Other effects of stigma are less obvious, but still impactful. Some advocates have linked the struggle for gay marriage in the U.S. to HIV risk, suggesting that the right to marry would reduce HIV transmission by promoting monogamy among MSM as well as providing economic benefits and increasing access to health care (Natale, 2009; Wohlfeiler, 2000). Furthermore, homophobia and heterosexism are tied with racism in complex ways. African American, Asian American, and Latino MSM often face a double jeopardy of magnified homophobia in many racial and ethnic minority communities and marginalization and sexual objectification in predominantly white gay communities (Natale, 2009; Peterson & Jones, 2009; Wilson & Yoshikawa, 2004). For example, in Natale's (2009) qualitative study, African American and Latino MSM in Denver linked experiences of feeling devalued or objectified in the majority-white local gay community with engaging in risk behaviors, such as drug and alcohol use and unprotected sex.

While not directly addressing homophobia, Barnett (2008) links poverty and oppression to an “ecology of hope” explaining HIV risk (p. 238). In this view, social, economic, and political structures regulate risk, and when these structures are so oppressive as to limit an individual’s hope for the future, he or she has limited motivation or ability to make choices that lead to a healthy future. From this perspective, the fact that sexual minorities are systemically denied social, economic, and political rights influences hope and decision-making in the context of HIV risk. Therefore, working to change these oppressive structures stands to positively impact the HIV risk environment at multiple levels.

Understanding homophobia and heterosexism as structural influences on HIV/AIDS risk and health has several implications for structural social workers. Within dialogical relationships with service users, social workers can facilitate critical consciousness through the use of critical questioning, political education, and social empathy. This may help service users connect their health and risk behaviors to the heterosexism inherent in dominant ideologies, such as the idea that gay men might as well be promiscuous since traditional marriage and family life are not available to them, or the sense of hopelessness that some gay men of color may feel in the face of homophobia, racism, and gendered ideologies about what constitutes a masculine identity and role. In this instance, collectivism and connecting gay and transgender service users with one another and with activist groups is a potentially powerful strategy, both in terms of facilitating critical consciousness and working to achieve social and political change.

Case Study: Structural Social Work with a Service User at High HIV Risk

A case study helps to illustrate the structural factors influencing HIV risk and health, and the approaches structural social workers can use to address them. Consider the following story of William, a fictional case based on the author’s social work practice experiences:

William is a 22 year-old African American man living in an impoverished community in a large Midwestern city. He was asked to leave his home three years ago after coming out as gay to his parents. Since then, he has bounced between different living situations, sometimes staying with friends, renting rooms at transitory hotels, or living on the street. William graduated from high school but has had difficulty finding stable employment. When he needs money or a place to stay, William sometimes has sex with other men in exchange for money or housing. He reports that he does not always use a condom when having sex. William periodically uses marijuana or crack to “escape.” He describes feeling hopeless: “What does it matter if I get sick anyways? I don’t have a place to stay, I can’t find a job, I don’t have many friends, I can’t go back to my family. What do I have to live for?” William does not have health insurance, and has not seen a doctor in a couple of years. When he last visited the local public health clinic, he says he experienced negative attitudes from staff after he told them he was having sex with men, so he does not want to return there. William does not know his HIV status.

Structural synopsis. While it is William’s individual behaviors—namely having sex without condoms, exchanging sex for money, periodic drug use, and avoiding medical care—that directly affect his health and HIV risk, these behaviors have clear structural influences. At a proximal level, William’s housing situation is directly linked to his drug use (“using to escape”)

and his need to exchange sex for money or a place to sleep. At the community level, the neighborhood public health clinic is a potential resource for William, but his access to it may be limited both by his lack of insurance and discrimination by the service providers there. Macro-level structural inequalities are interlaced with these factors. Poverty has severely limited William's housing options, and necessitates his exchange of sex for money and shelter. His family's homophobia appears to be a precipitator of William's homelessness. Though not explored in the case study, racism, ageism, and homophobia may be linked to William's difficulties finding a job or connecting with friends.

Structural approach to practice. Like all social work, structural social work begins with relationships. In this case, a social worker in virtually any medical or social service setting will have access to power and resources that William does not have. The structural social worker should be mindful of this power and acknowledge the skills, experiences, and strengths that William brings to the relationship as they work together. Facilitating William's access to resources will be a priority. For example, the social worker might help William apply for Medicaid, food stamps, or subsidized housing, but should make sure William is aware of the implications of applying for and receiving such types of aid, such as if a religiously based housing program would be accepting of his sexuality. Because poverty is so closely linked to William's living situation and HIV risk behaviors, the social worker should work with William to increase his financial resources, ideally through employment, since William appears to be wanting and able to work. While the social worker might help William get an HIV test or drug treatment if he wishes, these should not be preconditions for William receiving other assistance.

William's sense of hopelessness appears to be linked to his engagement in behaviors that put him at risk of contracting HIV, or transmitting the virus to others if he is HIV positive. Critical consciousness would help William make connections between his hopelessness ("What does it matter if I get sick anyways?"), his homelessness and drug use, and the discrimination and marginalization he has experienced related to homophobia, racism, and classism. Connecting William with other young gay men of color in a support or advocacy group will increase William's sense of support and may also facilitate critical consciousness. Together and with other service users, William and the social worker might work toward structural change goals including advocating for more affordable and subsidized housing in William's neighborhood, demanding specialized and sensitively provided healthcare services at the local clinic, and fighting homophobia, such as by advocating for gay rights and directly challenging personal and institutional instances of discrimination.

Conclusion

Structural social work is more than a theory or practice approach. In the words of Mullaly (2007), it is "a way of life," a perspective for viewing social work and the world (p. 362). This perspective has the potential to transform social work with people affected by HIV/AIDS. Being HIV positive is a stigmatizing condition, and the groups most at risk for contracting HIV are already oppressed and marginalized in other ways. In direct practice with groups and individuals, the structural perspective is useful in shifting social workers' attention to the structural dimensions of service users' health and risk and working to address these inequalities, instead of focusing solely on changing individual behaviors without attention to the broader social and

political context. While they have not been evaluated as extensively as standard behavioral interventions, there is great potential in collective, community-led structural approaches to preventing and addressing HIV/AIDS (Amon & Kasambala, 2009; Blankenship, Biradavolu, Jena, & George, 2010; Campbell & Cornish, 2010).

However, structural social work does not end in the clinic, hospital, or office. True structural social work practice requires going beyond social workers' prescribed workplace roles and committing personally and professionally to ending the structural inequalities that not only perpetuate HIV/AIDS, but continue to privilege some members of society at the expense of others in myriad ways. Living this commitment may involve policy work, advocacy, engagement in electoral politics, and the creative resistance of both social workers and services users. In this way, social workers' lives, work, and politics can reflect the profession's values of humanism, egalitarianism, and social justice.

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