Dímelo (tell me about it):
What influence does social stratification have on attitudes towards HIV/AIDS and Homosexuality among Latinos?

by

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Abstract

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The following study places an emphasis on organized religion as a social structure reinforcing social stratification through religious beliefs and implications for attitudes towards People Living With HIV/AIDS (PLWHA) and homosexuality among Latinos. Latinos (N = 312) were recruited via email throughout the U.S. to complete a self-administered online survey. The findings reveal that religiosity and spirituality should not be utilized interchangeably. Greater levels of religiosity were significantly correlated with lower levels of acculturation, greater levels of traditional gender-related attitudes, greater levels of spiritual well-being, lower levels of educational attainment, greater negative attitudes towards PLWHA, and greater negative attitudes towards homosexuals. Spirituality was only significantly correlated (positively) with religiosity and household income. A multiple linear regression analysis was selected to determine the relationship between outcome variables and multiple predictor and intervening variables. Educational attainment and acculturation accounted for 11% of the variance in HIV/AIDS knowledge, $R^2 = .11$, $F(3, 266) = 10.68$, $p<.001$. Traditional gender-related attitudes accounted for 9% of the variance in attitudes towards PLWHA, $R^2 = .09$, $F(2, 247) = 11.73$, $p<.001$. Acculturation, educational attainment, age, and traditional gender-related attitudes

accounted for 23% of the variance in attitudes towards homosexuals, R^2 = .23, F(5, 236) = 13.58, p<.001. Recommendations are made for professionals to collaborate with religious communities in developing services that integrate religious beliefs in addressing HIV transmission and taboo subjects such as premarital sex, condom use, substance use, and homosexuality in the community.

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Thanks to all of the participants that have taken time out of their busy schedule to share their thoughts about religion, culture, HIV/AIDS, and homosexuality. The Gay, Lesbian, Bisexual, and Transgender (GLBT) community of color has also played an integral role in educating me about their lived experiences, which has been the primary reason for conducting this research study. Colleagues from historically oppressed populations have also pointed out the significance of addressing the barriers and obstacles that social stratification imposes on oppressed and marginalized communities, which reminded me why this work is important. This dissertation would not be possible without the selfless support from the community.

I greatly appreciate all of the support and advice Dr. Bernadette R. Hadden has provided in guiding my professional trajectory and bringing to fruition my dissertation. Dr. Willie Toliver and Dr. Martha Bragin have played an essential role in sharing their wisdom in helping me further develop the dissertation. Thanks to Dr. Harriet Goodman for listening and advising me throughout the doctoral program. Much gratitude is given to the faculty mentors, whose time and energy has been invested in my overall development as a practitioner, researcher, and administrator.

Most of all I would like to thank my parents Ana and Filiberto García for sacrifices they have made to provide for the family and instill in me the significance of addressing the needs of less privileged populations. Ana García continues to inspire me to become a better person and exceed expectations. Thanks to my brother Filiberto García Jr. for keeping me grounded and sharing his wisdom. My nephews Cristian and

Noel García continue to be the catalyst for me to move forward. Every single family member has provided me with the strength to move ahead and overcome obstacles.

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Glossary

ABC – Abstinence, Be faithful, and correct and consistent Condom use.

Active Fundamentalism – religious members seek to expand their enclave into society and they take an active role in recruiting people outside of their enclave and/or preach the word of God; their desire to expand leads to direct confrontation with the enemy/outsiders that conflict with their religious beliefs and values.

Activo – active/top, which is the male that penetrates the bottom male during sexual intercourse.

ADAP – AIDS Drug Assistance Program

AHP – Advancing HIV Prevention

AIDS – Acquired Immunodeficiency Syndrome

APA – American Psychological Association

ASO – AIDS Service Organizations

AZT – azidothymidine;, medication for HIV/AIDS

Castas – a hierarchical system enforced by the Spanish colonizers in Mexico to maintain status based on various factors (e.g., class, race, gender, education, social ties), which placed "pure" Spanish Europeans at the pinnacle of the hierarchy.

CDC – Centers for Disease Control and Prevention

Celebrities – spokespersons of the elite and their status is dependent on the publicity and entertainment industry, which also includes people of color.

Chicano identity – a person that acknowledges the richness of one's Mexican culture and takes a political position in the U.S. to advocate for the rights of "*la raza.*"

CIA – Central Intelligence Agency

Concentrated Epidemic – the greatest impact of HIV prevalence rates occur among populations engaged in "high-risk" behavior, which includes: MSM, IDU, and CSW (USAID, 2009).

Contra-acculturation – religious members discourage acculturation into mainstream society and they reinforce homogeneity of a religious lifestyle within the enclave.

CSW – Commercial Sex Workers

CUSH – Churches United to Stop HIV

DL (Down Low) – black men that identify as heterosexual and have female primary partners (e.g., wife, girlfriend), but they also maintain a secret life and have sexual encounters with other men.

DADT (Don't Ask, Don't Tell, and Don't Pursue) – litigation regarding homosexuals in the military, implemented in 1993

DoD – Department of Defense

DSM – Diagnostic and Statistical Manual

El mas Chingon – the biggest fu--er

Enclaves – religious fundamentalist communities that preserve their religious ideology with designated boundaries for members to distance themselves from outsiders.

Ethnic Identity – a composition of various factors that are not stagnant, but dependent on an individual's understanding of the self in regards to: "…culture, phenotype, religion, language, kinship, or place of origin" (Phinney, 2002).

FAIR – Federation for American Immigration Reform

FBCI – Faith Based and Community Initiative

Glossary (continued)

FBO – Faith Based Organizations

Gatekeepers – people that lie within the multiple layers of hierarchy that are designated as authority figures (e.g., religious leaders, police, teachers) who reinforce social norms and subjugate social "deviants," which also include people of color.

Generalized Epidemic – the greatest impact of HIV prevalence rates occur among the general population, which tends to have a greater burden on females and is concentrated in the region of Sub-Saharan Africa (USAID, 2009).

Gini Index– a measure used to determine levels of inequality based on distribution of resources within a country;, zero indicates that there is perfect equality and 100 indicates that there is perfect inequality (Bacon et al., 2005).

GLBT – Gay, Lesbian, Bisexual, and Transgender

GRIDS – Gay Related Immunodeficiency Syndrome

HAART – Highly Active AntiRetroviral Treatment, medications for HIV/AIDS

HDI (Human Development Index) – measures the overall well-being of the population, which is a combined measurement of health, education, and income (UNDP 2009).

HIV – Human Immunodeficiency Virus

Homogenitality – sexual behavior between two people of the same sex.

HRSA – Health Resources and Services Administration

IDU – Injection Drug User

Jotos – fags

La Raza – Mexican Race

Machismo – a measure of masculinity among Latino males, which stigmatizes Latinos as sexually aggressive violent males that disregard others in their conquest.

Manichean Beliefs – religious fundamentalists stress extreme differences between enclave members and nonreligious outsiders; a dualistic frame of thought is created where anything that contradicts or deviates from the religious enclave is considered as implausible or evil.

Marianismo – a measure of femininity among Latina females, which stigmatizes Latinas as docile fragile females that are unable to communicate or advocate for their rights.

Mayates – straight identified MSM

Mestizo – person of Indian and Spanish descent

Metrosexual – a heterosexual man that takes extra effort to maintain his appearance through various activities that were once considered highly effeminate such as eyebrow plucking, manicure, and waxing.

Mexican-American identity – a person that acknowledges one's ancestry of Mexican descent and birth in the US, but assimilation into American culture may override Mexican beliefs and values.

Modernos – a partner that takes the active and passive role during a homosexual encounter.

MSM – Men who have Sex with Men

NGO – Non Government Organization

OFBCI – Office of Faith Based and Community Initiatives

Glossary (continued)

OHCHR – Office of the United Nations High Commissioner for Human Rights

Pasivo – passive/bottom, which is the male that gets penetrated by the top male during sexual intercourse.

PEPFAR – President's Emergency Plan for AIDS Relief

PLWHA – People Living With HIV and AIDS

Power Elite – a concentrated small group of powerful men and women (e.g., politicians, oligarchies, religious leaders, colonialists) that determine what is best for society and enforces social structures to maintain their power and control of society.

Putos – men that get f---ed, bottoms.

Quiescent Fundamentalism – the step prior to active fundamentalism for an enclave to establish a homogenous religious group based on similar traditional religious beliefs and values; religious members avoid confrontation with outsiders and isolate themselves within the enclave.

Race – social constructs created by the government to categorize people such as black, white, Latino, and American Indian (Williams & Collins, 1995).

RCOPE – Religious/Spiritual Coping scale

SAI – Spiritual Assessment Inventory scale

Sexiles – people who need to leave their community or country due to their homosexual orientation.

Social Stratification – inequality is reinforced by the power elite and gatekeepers through multiple factors such as race, biological sex, and sexuality within as well out of historically oppressed and highly marginalized populations.

Social Structure – an institution (e.g., government, religious organization, academic institution) or a group of people with designated beliefs and values that influence behavior within their social network.

SWBS – Spirituality Well-Being Scale

Traditionalism – reinforces the advantages of maintaining a religious lifestyle for a better future.

Triangle of Power – three dominant institutions (i.e., economic, political, military) controlled by the power elite that designate policies among the nation and capitalize on existing resources.

TRIPS – Trade-related Aspects of Intellectual Property Rights

UDHR – Universal Declaration of Human Rights

UN – United Nations

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNDP – United Nations Development Programme

USAID – United States Agency for International Development

1. Introduction: Statement of the Problem

This study explores the role Christian religious institutions have in reinforcing religious rhetoric associated with HIV/AIDS and homosexuality in the general Latino community. The Global HIV Prevention Working Group (2007) reports that there have been significant advancements made in HIV/AIDS treatment, but prevention initiatives have failed in maintaining the momentum to address the needs of vulnerable populations such as Men who have Sex with Men (MSM), Injection Drug Users (IDUs), and Commercial Sex Workers (CSW). Failure to address the needs of vulnerable populations is not limited to low or middle income states. HIV incidence and prevalence rates continue to rise among people of color in the U.S. and they are disproportionately impacted by the epidemic (Diaz, 1998; González, 2007; González-Figueroa, Koniak-Griffin, Kappos, Castañeda, Corea-London, & Morgan, 2006). Urban poverty-stricken areas reported an HIV prevalence rate of 2.1% in the U.S., a rate comparable to Burundi, Ethiopia, Angola, and Haiti (Denning & DiNenno, 2010). HIV prevalence rates have stabilized for white MSM even as the epidemic continues to spread among historically oppressed and highly marginalized populations.

Researchers have emphasized the need to explore beyond behavior and take into consideration the social, cultural, and psychological issues that affect HIV transmission among historically oppressed populations. For example, social stressors such as racism, unemployment, and homophobia have affected gay Latino male efforts at practicing safer sex (Diaz, 1998). Brooks and colleagues (2005) found that stigmas associated with HIV/AIDS and homosexuality limited effective HIV prevention and intervention services from reaching Latino MSM. Gay Latino males experience a disassociation between intended behavior and actual behavior (Diaz, 1998). Gay Latino males know how to, and

indicate that they intend to reduce their risk of exposure to HIV transmission, but they still partake in risky behavior. While there are many studies on populations affected by the HIV/AIDS epidemic there is a significant gap in the research exploring how social structures (e.g., religious institutions) reinforce social stratification (e.g., levels of religiosity, socioeconomic status, sexual identity) and the implications for HIV/AIDS particularly among Latinos.

Chapter two will focus on the historical perspective of homosexuality and the HIV/AIDS epidemic as a social problem in the U.S. The discussion will include the role of the power elite (e.g., President, government, CDC) in stigmatizing a sexual minority as social deviants and the influence the power elite had on responding to the HIV/AIDS epidemic. The literature shows that homosexuals have been stigmatized as criminals, mentally pathological, a health threat in spreading HIV/AIDS, and are currently perceived as a moral threat to family values. The subjugation of homosexuals by the power elite provides critical insight into: 1) how inequality is reinforced within a sexual minority, and 2) the failure to address the health epidemic largely because of the misconception during the early years of the epidemic in the 1980s that HIV was transmitted only between gay men.

The first recognition of HIV/AIDS was categorized as Gay Related Immunodeficiency Syndrome (GRIDS) and seen predominantly among white homosexuals, but similar cases of GRIDS started to appear among IDUs. The power elite perceived HIV/AIDS as a cleansing of social deviants (e.g., homosexuals, drug users, sex workers) who were being punished for their immoral behavior. When HIV/AIDS cases

started to appear among vulnerable innocent white children the power elite realized the threat of HIV to the white community and began to take action.

The HIV/AIDS epidemic has stabilized in the white community, but it continues to spread among historically oppressed and highly marginalized communities. The HIV interventions that were successful in curtailing prevalence rates among MSM were implemented in communities of color (e.g., blacks, Latinos), but people of color initially never perceived HIV as a threat because the media portrayed it as a disease among gay white men. In addition, many of the HIV interventions did not address the complexity of racism, oppression, discrimination, and the obstacles that people of color encountered in their daily lives.

Although the focus of this study is on the Latino community there are relatively few studies on this community's response to the HIV/AIDS epidemic. Therefore, the current study reviewed the impact of the HIV/AIDS epidemic in the black community to demonstrate the impact of social stratification of power within a historically oppressed population in the U.S. The Latino and black community share a common experience and vulnerability of being historically oppressed populations, which is reinforced by the power elite that have developed social structures to reinforce inequality. Obstacles associated with inequality such as access to education, heath care, employment, and housing among historically oppressed populations in addition to being part of a highly marginalized group (e.g., MSM, CSW, IDU) fuel the spread of the HIV/AIDS epidemic among Latinos.

A social structure is defined as an institution or a group of people with designated beliefs and values that influence behaviors within their social network. Chapter three

focuses on power elite theory (Mills, 1956) and queer theory (Jagose, 1996) as the primary/predominant perspectives for this research study. Power elite theory places an emphasis on how power is harnessed through social structures and how ideology is reinforced in society to maintain dominion over the classes. According to power elite theory, a hierarchy of power is established in a designated society, such as the U.S. The people that lead/head social structures are at the pinnacle of the power elite paradigm and reinforce social norms for a "civil" society. The hierarchy of power creates multiple layers of power and status (i.e., social stratification) to reinforce what is acceptable and unacceptable behavior in society. Queer theory places an emphasis on how the power elite reinforce patriarchic social structures and how inequality is reinforced to subjugate minorities based on race, gender, and sexuality. Therefore, power elite theory and queer theory provide the theoretical perspectives that guide and frame the design and findings of this study.

A distinction must be made between power elite leaders and gate keepers within the power elite hierarchy. At the top of the hierarchy are power elite leaders composed of predominantly affluent white men due to their historical influence in colonizing the Americas and control of resources. The tier that follows is composed of gatekeepers, who reinforce the structures put in place by the power elite leaders. The gatekeepers are authority figures (e.g., religious leaders, teachers, politicians, police) including people of color, who reinforce society's norms and subjugate "deviants." This study looks at social stratification and how race, class, sexuality, and gender influenced the role social structures have in addressing HIV/AIDS.

Religious institutions also played a significant role in reinforcing ideology from the power elite during the colonization of the Americas, which has persisted throughout time. Chapter four provides an overview of how Christian religious leaders reinforce religious ideology in the community and the implications of this behavior for reinforcing stigmas among highly marginalized populations (i.e., homosexuals, HIV/AIDS). Religious leaders utilize biblical scriptures to guide religious followers towards salvation, but the problem is that the Bible is an ancient text that has gone through numerous interpretations. This chapter will examine five biblical passages (i.e., Sodom & Gomorrah, Leviticus 18:22 & 20:13, Saint Paul's Letter to the Romans 1:27, 1 Corinthians 6:9, Timothy 1:10) that the religious community reference to condemn homosexuality. Chapter two emphasizes how homosexuality has evolved into a modern social identity, but homosexual behavior has been evident throughout history. The section on religious ideology shows that modern interpretations of biblical passages take homosexuality out of context because there was no homosexual culture at the time. Helminiak (2000) emphasizes that while there were limitations on homosexual behavior the Bible did not ethically condemn homosexuality as a culture and/or identity because it is a modern phenomenon. The section on religious ideology demonstrates how the power elite emphasizes homosexuality as a modern social problem, but they avoid consequences for other acts that the Bible condemns such as adultery, eating shell fish, masturbation, and premarital sex.

Religious institutions have historically addressed the needs of disenfranchised populations, but these services come with a price. The mission of religious fundamentalism is to become the dominant voice of political, social, and cultural life.

The Bible provides a foundation for Christian religious fundamentalists to discern right from wrong and determine who is headed towards a path of condemnation. The study looks at religious fundamentalism in Guatemala to demonstrate the implications that faith-based initiatives have on addressing the needs of historically oppressed and vulnerable populations. The allocation of U.S. government funds for faith-based initiatives to address HIV/AIDS among historically oppressed and highly marginalized populations creates a conflict of interest. Religious ideology that is dependent on the interpretation of biblical passages to condemn homosexuality, contraceptives, premarital sex, and adultery prevents religious organizations from effectively reducing risks related to HIV transmission. For example, abstinence is the best prevention for HIV transmission, but it is not always realistic in addressing the needs of young people. Condoms are also a very effective means of preventing HIV transmission when used consistently and correctly. Stigmas placed on premarital sex and/or adultery in the religious community may prevent one from utilizing condoms. Religious ideology that stigmatizes behaviors associated with sexuality and/or drug use may result in people internalizing the conflict between their religious beliefs and behaviors, which further increases their susceptibility to HIV infection.

The spread of HIV/AIDS has resulted in a pandemic that has left no state unscathed globally and despite the odds Brazil became an unexpected leader in addressing the epidemic. Chapter five looks at HIV/AIDS in Brazil as a model of how a state with limited resources is able to curtail the epidemic despite opposition from the power elite (e.g., USAID, World Bank, international pharmaceutical companies). Brazil was going through significant political change from a dictatorship to a democratic

government during the start of the HIV/AIDS epidemic. The political upheaval paved the way for activists to frame HIV/AIDS through a human rights lens and emphasize access to healthcare as a fundamental human right for everyone, as stipulated in Brazil's constitution. The spread of HIV increased demands that the government provide affordable medical treatment for its citizens. Escalating costs of HIV medications caused the government to produce affordable medications within the state and challenged international pharmaceutical patents to provide medications at comparable rates for low and middle-income states. The government of Brazil also had an influential role in establishing a faith-based initiative with the Candomblé religious community in addressing HIV/AIDS among historically oppressed (e.g., black Brazilians) and highly marginalized populations (e.g., MSM, CSW, IDU). Brazil's faith-based initiative provides critical insight into ways a government can partner with religious leaders to adapt interventions to the needs of the community.

A general literature review in chapter six highlights HIV interventions in the U.S. among historically oppressed (e.g., Latino, black) and highly marginalized populations (e.g., MSM). The literature demonstrates that there is limited information on the influence that social structures have in reinforcing discrimination and its implications for HIV/AIDS knowledge in the Latino community. HIV/AIDS interventions continue to have little success in reducing HIV incidence and prevalence rates among Latino and black communities. The epidemic continues to grow and disproportionately affects Latinos. This study will further explore the recommendations made by researchers (Ayala, Husted, & Spieldenner, 2004; Battle, Bennett, & Shaw, 2004; Diaz, 1998) and

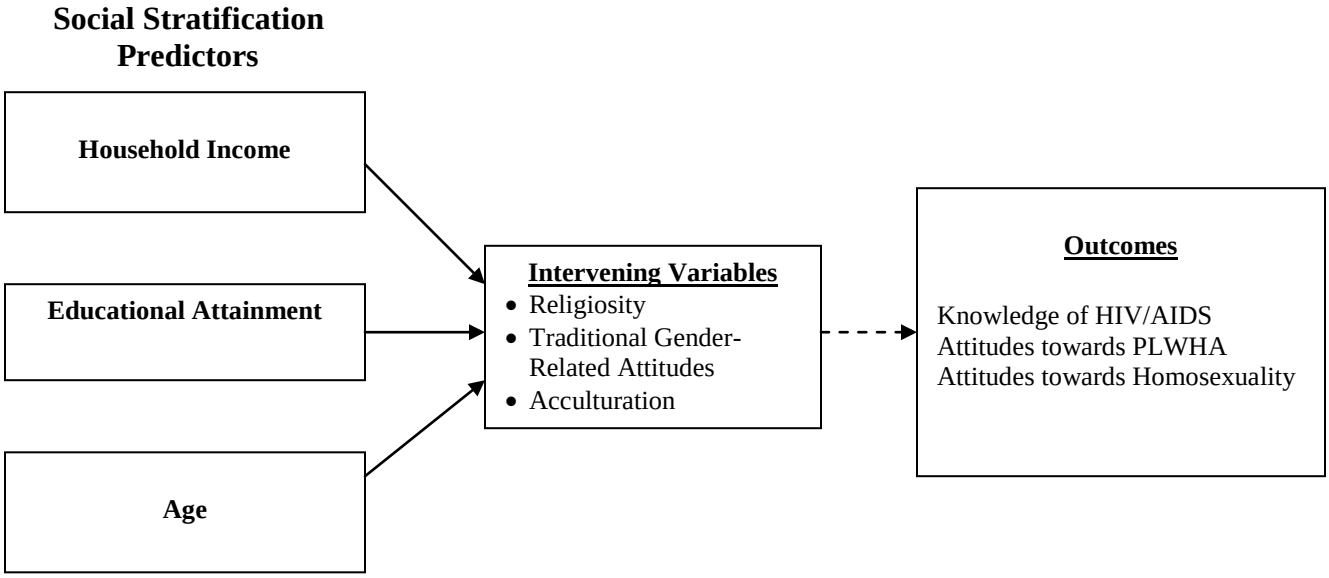
take into consideration how social, cultural, and psychological issues affect HIV transmission among Latinos.

Many questions remain unanswered regarding the influences of culture on risk behavior for HIV/AIDS among Latinos (González-Figueroa et al., 2006). Researchers (Diaz, 1998; González, 2007; González-Figueroa et al., 2006; Schiller, 1992) have expressed concern about the over-generalization of risk groups such as Latinos and MSM in HIV/AIDS studies. Researchers believe that many studies homogenize the population and disregard the complexity of cultures in terms of ethnicity (e.g., Mexican, Puerto Rican, Dominican) and sexual identity (e.g., straight, gay, bisexual). Schiller (1992) has indicated that the homogenization of populations such as Latinos and marginalized groups (e.g., MSM, IDU) has hindered efforts for interventions to successfully decrease HIV prevalence rates among oppressed populations. This research study seeks to explore the implications of acculturation and religiosity on HIV/AIDS among Latinos. Acculturation is a significant component of the study because it provides essential information such as ethnic social relations, media use, and language use among Latinos.

The following figure demonstrates a conceptual model for the relationship among variables influencing HIV prevention in the Latino community. The left column indicates the three social stratification predictors based on power and status: household income, educational attainment, and age. The intervening variables fall into three main categories: 1. Religiosity – looks at religious institutions as a social structure and the influence intrinsic and extrinsic religiosity has on reinforcing attitudes towards PLWHA and homosexuals; 2. Traditional gender-related attitudes – places an emphasis on reinforcing designated masculine and feminine gender roles among Latinos; and 3.

Acculturation – places an emphasis on the respondent's utilization of language and desired social network in reinforcing inequality within a historically oppressed population (i.e., Latinos). The outcome variables will show a focus on how knowledge of HIV/AIDS and attitudes towards PLWHA and homosexuality are influenced by the predictor and intervening variables.

Figure 1: Conceptual Model for Factors Influencing Attitudes among Latinos Towards PLWHA and Homosexuals



The research methodology for this study encompasses an exploratory and descriptive quantitative non-experimental research design. Power elite theory and queer theory are used to demonstrate the influence that power and status (i.e., age, household income, educational attainment) have on social stratification (i.e, religiosity, traditional gender-related attitudes, acculturation) within a historically oppressed population (i.e., Latinos) and implications for attitudes among Latinos towards PLWHA and homosexuals. The following three hypotheses are examined:

H_1 Latinos that report greater levels of HIV/AIDS knowledge will have:

- Reported younger age.
- Greater levels of household income.
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of levels of educational attainment.

H_2 Latinos that report lower levels of negative attitudes towards PLWHA will have:

- Reported younger age.
- Greater levels of household income.
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of levels of educational attainment.

H_3 Latinos that report lower levels of negative attitudes towards homosexuals will have:

- Reported younger age.
- Greater levels of household income.
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of educational attainment.

Findings from this study will contribute to the field of social work for both scholars and practitioners as it provides new findings as well as guidelines for services for individuals, groups, and communities. The findings will contribute to the limited literature available on the influence that social structures have in reinforcing ideology, social stratification, discrimination, and HIV/AIDS awareness. Individual and group level interventions will benefit from the focus on modifying behavior and providing resources (e.g., support groups, culturally sensitive services, HIV testing and counseling) to buffer against negative environmental factors (e.g., homophobia, discrimination, xenophobia) for Latinos. Community-level interventions in the Latino community can

learn from the Brazilian experience and use some of the strategies employed there to advocate for a change in existing beliefs and values that increase exposure to HIV transmission within the Latino community.

2. Historical Perspective

This chapter reviews the conceptualization of homosexuality as a social problem throughout history. Although homosexual behavior is documented throughout history the term homosexuality was first coined in 1868. The literature shows that homosexuals were first perceived as criminals, then as having a mental disorder, later as a social health threat, and currently as a threat to society's moral beliefs and values. A brief mention is made of religion's influence in condemning and stigmatizing homosexuality, but the impact of religion will be covered in detail in chapter four. This chapter places greater emphasis on the fluidity of discourse on homosexuality in the field of psychology and the evolution from stigmatizing homosexuality as a mental disorder to the removal of homosexuality in 1986 from the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Homosexuals were perceived as a social health threat due to the initial HIV/AIDS cases being identified among gay men. As the HIV/AIDS epidemic spread it was no longer stigmatized as a disease that only impacted gay men. However, the religious right continued to stigmatize homosexuals as a social threat to moral beliefs and values. A review on the evolution of HIV/AIDS sheds light on how the power elite blamed a highly marginalized population for an epidemic. This chapter attempts to show how stigmas propagated by the power elite oppressed a highly marginalized group, which fueled the fire of the HIV/AIDS epidemic.

2.1 *Perceptions and definition of Homosexuality*

The term homosexuality was first used by Doctor Karoly Maria Benkert in Switzerland in 1869 (Jagose, 1996). Shortly after, the term homosexual was used to label

people that have sex with the same sex (Jagose, 1996). Cannon (2005) states that there is no equivalent word for homosexual in biblical Greek or Hebrew; the word appeared for the first time in the revised New Testament in 1946. Cory (1951) emphasized that prior to the 1800's various forms of homosexuality existed internationally and were accepted among various cultures.

The Hebrews might not have been the first to condemn homosexuality, but they set the foundation of moral judgment for Judeo-Christianity and the homophobia that has persisted throughout time in influencing religious rhetoric (Cory, 1951). During the Middle Ages Europeans believed homosexuality was an abomination and known homosexuals were killed, which resulted in the oppression of a sexual minority. Homosexuality was seen as an abnormality, which was punishable by crime (Cory, 1951). The power elite (e.g., religious leaders, politicians, oligarchies, white men) argued that the sole purpose of sexual intercourse was to procreate and any other intent was a *perversion* of nature (Cory, 1951). Since sexual intercourse between homosexuals did not lead to reproduction it was seen as a blasphemous act.

Gender became a significant factor among the power elite who believed that homosexuality threatened the development of boys into men (Greenberg, 1988). Effeminate traits were seen as a sign of weakness and stigmatized as "inferior" among males (Greenberg, 1988). Homosexuality posed a greater threat to male supremacy, which in turn reinforced gender roles as a form of oppression towards homosexuals (Greenberg, 1988). Homosexuals were stigmatized as being highly effeminate and driven by their sexual desires for males, including boys (Greenberg, 1988; Troiden, 1988).

During the 19th century, American medical and psychiatric professionals began to develop another understanding of homosexuality as pathological (Herek, 2006; Troiden, 1988). Homosexuality was no longer criminalized, but in 1952 homosexuality was categorized as sociopathic personality disturbances in the DSM (Nicolosi, 2001). The transition of stigmatizing homosexuals as pathological reinforced power elite ideology and provided a source of revenue for the medical elite. The conceptualization of homosexuality as a pathology also provided an opportunity for professionals and activists to advocate for the rights of homosexuals. Theoretical models were developed to explain the source of homosexuality as a problem and activists utilized research findings to advocate for homosexual rights.

"In Freud's theory the human infant begins life with a sexual disposition which is polymorphously perverse and innately bisexual" (Dollimore, 1991, p.175). Freud believed that any sexual activity that was done for pure pleasure and did not result in reproduction resulted in a perversion (Dollimore, 1991). Dollimore (1991) reports further that Freud believed that socialization and genderfication conditioned one to repress his/her "perversions" and reinforced order in a heterosexual civil society. Freud conceptualized homosexuality as a *perversion* based on the object of desire, which was a person of the same sex (Dollimore, 1991). Freud further indicated that sexual repression drove *perverts* to become productive members of society (Dollimore, 1991). In essence, everyone is born with a *perversion*, but it is the ability to control the *perversion* that allows one to become a productive member of society. A civil society requires order and norms, which a *pervert* is unable to accomplish due to his/her uncontrollable desire for sexual activity.

Foucault (Dollimore, 1991) believed that *perverts* are central to society, but he disagreed with Freud's conclusions. Foucault believed that *perverts* are a social construct created by the power elite (Dollimore, 1991). Social organization and control is achieved by creating a hierarchy of power, which is centralized through oppression and stigmatization of homosexuality as a sexual perversion and/or social deviance. Society is unable to identify the source of power and therefore becomes the unwitting catalyst for centralizing that power (Dollimore, 1991). Hence, heterosexist constructs are reinforced in society and the power elite reinforces gender norms to oppress the homosexual minority.

Thomas Painter (as cited in Minton, 2002) was an ethnographic sex researcher who viewed homosexuality as a "psycho-physical" condition. He believed that homosexuals were unable to maintain a committed same sex relationship and fall in love. Painter's beliefs and lived experience of homosexuality was instrumental in shedding insight into the homosexual mystique and his work played a critical role in Alfred Kinsey's research (Minton, 2002). Painter conducted research among homosexuals and discussed how psychological, biological, and social factors influenced the lives of homosexuals (Minton, 2002). Painter's intent was for society to acknowledge that homosexuality was not a disease; he wanted greater initiatives taken to provide equal status for homosexuals in a heterosexual society (Minton, 2002). Unfortunately, much of Painter's work was disregarded at the time due to his sexuality, but his work with Kinsey encouraged him to pursue his research (Minton, 2002).

Kinsey's (Herek, 2006) research focused on sexual behavior and sheds light on the fluidity of sexuality from heterosexuality to homosexuality and found that only 10%

of his male sample was exclusively homosexual. Painter assisted Kinsey in his research with critical information on homosexuals and recruited a diverse sample of homosexuals to participate in Kinsey's study (Minton, 2002). The Kinsey Reports provided critical findings on sexual taboos that had never before been talked about in society (Minton, 2002). Kinsey never stigmatized men who had sex with men as homosexuals regardless if their sole sexual partners were males and considered everyone as an individual within a spectrum of sexuality ranging from exclusive heterosexuality to exclusive homosexuality (Minton, 2002). Kinsey also believed that homosexuals should not be considered pathological and that homosexuality is a universal biological behavior expressed among animals as well as humans (Minton, 2002). Kinsey's research provided essential data for the queer movement in advocating for equal rights. Consequently, as research on homosexuality increased the economic boom in the 1950s shifted the roles of men and women, which placed less of an emphasis on family oriented values and a greater emphasis on obtaining wealth. A sense of identity in society centered more on one's role of employment and consumer capitalism.

Kinsey's research played a prominent role in making homosexuality visible, but the development of the economy provided an opportunity for gay men to become financially stable. Homosexuals no longer had to reinforce patriarchal structures to gain satisfaction in their lives (Jagose, 1996). Homosexuals gained economic independence and began to socialize with one another, which gave rise to a gay and/or queer identity. Gay men were able to have lucrative careers, but remained cautious about disclosing their sexuality in order to avoid discrimination in the workplace. A homosexual culture became established and offered an opportunity for men to discuss shared experiences and

develop a political agenda (Jagose, 1996). The homophile movement was the first organized group of homosexuals that used literature to increase awareness of homosexuals in society (Jagose, 1996). Homophiles wanted to demonstrate to society that they were just as normal as everyone else (Jagose, 1996).

2.1.1. *Mattachine Society*

The homophiles established the Mattachine Society in 1950, which encouraged homosexuals to fight against oppression through a homosexual identity (Jagose, 1996). The founders of the Mattachine Society were actively involved in the Communist party, which provided a model for a secretive hierarchical structure that ensured privacy for its members and prevented persecution based on their sexuality (D'Emilio, 1983). Members shared their lived experience as a homosexual to conceptualize how homosexuals were oppressed as a cultural minority because of their sexuality (D'Emilio, 1983). The Mattachine Society's goal was to assimilate into society and demonstrate that homosexuals are just as respectable as heterosexuals (Jagose, 1996). They drafted a one-page proposal to encourage other homosexuals to become members using non-Marxist language in order to appeal to a larger audience (D'Emilio, 1983).

A group of faculty members from the University of California Los Angeles (UCLA) joined the Mattachine Society, which provided an academic perspective on studying literature and theories about homosexuality (D'Emilio, 1983). The Mattachine Society, homophiles and gay liberationists were a privileged group that were highly educated and had access to resources, including a political and academic approach towards advocating for the rights of homosexuals. The Stonewall liberation on the other hand was lead by people of color and transgenders.

2.1.2. *Stonewall & the Gay Liberation Movement*

The power elite abused their role and encouraged authorities to "control" sexual deviants, which resulted in police openly harassing and arresting homosexuals. Discrimination by the power elite caused an underground homosexual culture. Social clubs and bars would not openly cater to homosexuals. The Stonewall Inn however was known to cater and profit from homosexuals. An emphasis is placed on the Stonewall Inn due to its significant role in the gay movement. Stonewall Inn was and continues to operate in the heart of Greenwich Village in New York City, but in the 1960s it had no liquor license (D'Emilio, 1983). Homosexual patrons and male strippers (i.e., go-go boys) that provided entertainment for the clientele at Stonewall were predominantly young people of color, which included drag queens (D'Emilio, 1983). Stonewall became a prime target for police harassment during the era when homosexuality was being stigmatized as a sexual perversion. On June 27, 1969, police conducted what they assumed would be a routine raid, but instead they encountered resistance from the patrons at Stonewall Inn (D'Emilio, 1983). Stonewall became an epicenter for transgenders leading a riot against the police and the beginning of the gay liberation movement. D'Emilio (1983) describes the scene:

> At the intersection of Greenwich Avenue and Christopher Street, several dozen queens screaming "Save Our Sister!" rushed a group of officers who were clubbing a young man and dragged him to safety. For the next few hours, trash fires blazed, bottles and stones flew through the air, and cries of "Gay Power!" rang in the streets as the police, numbering over 400, did battle with a crowd estimated at more than 2000. (p.232)

The Stonewall riot became a historical and pivotal event for the nationwide liberation movement of the Gay, Lesbian, Bisexual, and Trnsgender (GLBT) community, but there

is limited emphasis on the role that people of color and the transgender community played in standing up for their rights and mobilizing the gay liberation movement.

The chapter on theory discusses power elite theory and the implications race, class, and sex have on how resources are disseminated, as well as how experiences are written in the media and placing a greater emphasis on the activities of the dominant group. The gay liberation movement at Stonewall created a political divide between the homophiles and gay liberationists in the Mattachine Society (Jagose, 1996). The homophiles reinforced the Mattachine Society's goal and encouraged homosexuals to assimilate into society and maintain a respectable demeanor like heterosexuals (reinforce gender norms – males dressing and acting as males and females dressing and acting as females); direct confrontation was highly discouraged and frowned upon. Gay liberationists on the other hand believed that heterosexual dominance should be addressed through confrontation; homosexuals should not have to modify their behavior and society should regard them as a distinct community (Jagose, 1996).

The chapter on theory also discusses social stratification and the influence it has on gate keepers from historically oppressed populations and the innate need to prove to the dominant group that they (e.g., homosexuals) are just the same as them (e.g., power elite – white heterosexual community). The Mattachine Society was composed of academics and non-academics, which caused a conflict on the movement's trajectory. The academic group advocated assimilation into society while the highly progressive non-academic group also known as gay liberationists refused to reinforce social norms (e.g., gender norms – males acting masculine in order to be accepted by society). The gay liberationists set the foundation for the queer movement and queer theory.

2.1.3. *Queer Movement & Queer Theory*

The queer movement wanted to remove the label of mental illness from homosexuality. Evelyn Hooker, an influential psychologist, strengthened this movement (Minton, 2002). Hooker did not believe that gay men were pathological and conducted research to support her premise. Hooker's initial study recruited a sample of 30 homosexual and 30 heterosexual males to participate in a study that measured psychological maladjustment through personality tests (Minton, 2002). Her research (although the sample sizes were small) demonstrated that there were no distinguishable trait differences between homosexuals and heterosexuals, other than sexual behavior; the findings debunked common myths and stereotypes about homosexuals (Minton, 2002). Hooker, a self-identified heterosexual, was afforded more credibility and recognition due to her status as a heterosexual and received greater funding opportunities (Minton, 2002). Homosexuals were considered by the power elite to be pathological and incapable of conducting sound or "respectable" research. Hooker presented her findings at an American Psychological Association (APA) conference, which garnered greater support to conduct further research in the area of homosexuality to support her findings (Minton, 2002).

2.1.4. *American Psychological Association (APA) & Homosexuality*

Queer advocates had the research necessary to support their claim that homosexuals were not pathological and succeeded in having the APA remove homosexuality as a pathology from the DSM in 1974 (Herek, 2006; Minton, 2002). The DSM III written in 1980 introduced the term ego-dystonic homosexuality, which categorized patients that were unable to have wanted heterosexual intercourse and

experienced distress due to their unwanted homosexual arousal (Herek, 2006). Queer advocates however, remained persistent in having any stigmatizing label removed from the DSM stating that the majority of homosexuals go through an ego-dystonic homosexual phase (Herek, 2006). Efforts to further remove stigmas for homosexuals were accomplished in 1986 and ego-dystonic homosexuality as a diagnostic label was removed from the DSM III (Herek, 2006; Minton, 2002).

2.1.5. *HIV/AIDS & Homosexuality*

Beginning in the early 1980's, the HIV/AIDS epidemic caused queer activists to mobilize and become inclusive of other marginalized groups such as sex workers, injection drug users, and transgenders. The power elite stigmatized HIV/AIDS as the "gay cancer." Society blamed homosexuals for causing an epidemic instead of addressing HIV/AIDS through interventions targeting unprotected sexual behavior and IDU as the primary modes of transmission (Jagose, 1996). Homosexuality became a death sentence and the cause of a health crisis (Jagose, 1996). The queer movement encouraged the government to take action in addressing HIV/AIDS, which caused public health professionals to revise initiatives in addressing the epidemic (Jagose, 1996).

2.1.6. *Sexual Revolution*

Troiden (1988) suggests that the sexual revolution in the 1960s generated the public's revolt against traditional values and redefined traditional scripts. Procreation was no longer reinforced through the sanctity of marriage, sex between consenting adults became an acceptable form for having children (Troiden, 1988). Recreational sex also became more acceptable and prevalent (Troiden, 1988). Sexual norms became more liberal and sex became an outlet of expression, one of which was homosexuality.

Homosexuals embraced the sexual revolution, which resulted in the creation and celebration of various venues (e.g., bath houses, parks, tea rooms) where people could engage in homosexual intercourse (Troiden, 1988). The gay community evolved and developed a political agenda that challenged the idea of homosexuality as a mental pathology and worked to gain acceptance for homosexuals as equal citizens (Troiden, 1988). Once homosexuality was removed from the DSM as a mental pathology, research interests shifted to the development of a homosexual identity (Troiden, 1988).

The removal of homosexuality from the DSM also caused the religious right to reemphasize homosexuality as a social problem. Sexual promiscuity threatened the "morality" of society and the religious right perceived homosexuality as the source of HIV/AIDS. The religious right reemerged as a powerful force in the U.S. and began to emphasize the need for society to strengthen sexual morality and marriage (Troiden, 1988). The power elite have taken drastic measures throughout history to oppress and stigmatize homosexuality, first as criminals, then as mentally ill, to a social health threat (i.e., spreading HIV/AIDS) and currently as a social threat to moral values and beliefs.

2.2. *The Evolution of the HIV/AIDS Epidemic*

The initial signs of HIV/AIDS in the U.S. were seen among gay white men in 1978. At the time, no information existed on the treatment or prevention of the disease now known as HIV/AIDS. Medical practitioners originally referred to AIDS as Gay-Related Immunodeficiency Syndrome (GRIDS) since it was originally believed that the disease was isolated among gay men (Osmond, 2003). Shortly thereafter it was discovered that non-gay IDUs also acquired the same disease. The spread of AIDS to heterosexual IDUs caused researchers to speculate that it was blood-borne and sexually

transmitted. In 1982, the Centers for Disease Control and Prevention (CDC) labeled the disease AIDS and indicated that it was found in blood (AEGIS, 2005). In 1983, HIV was identified as the virus that caused AIDS (AEGIS, 2005). Identification of the HIV virus paved the way to a better understanding of how the virus progressed to a syndrome defined as AIDS, which resulted in medical advances to treat the virus and a comprehensive case definition for AIDS diagnosis. Barclay (2008) summarizes the 2008 case definition for HIV and AIDS among adults and adolescents:

> Specific revisions are as follows:
>
> - For adults and adolescents aged older than 13 years, the HIV infection and AIDS classification system and surveillance case definitions have been revised and combined into a single case definition for HIV infection.
> - The surveillance case definition in this group requires laboratory-confirmed evidence of HIV infection. The stage of infection is determined from the lowest CD4+ T-lymphocyte count (or concordant CD4+ T-lymphocyte percentage of total lymphocytes) or from the presence of AIDS-defining conditions.
> - When the CD4+ T-lymphocyte count and the CD4+ T-lymphocyte percentage do not correspond to the same severity stage, the case should be classified as the more severe stage.
> - Acute HIV infection, which occurs approximately during the time from viral acquisition until seroconversion, is diagnosed from documented, detectable HIV RNA or DNA or p24 antigen in plasma or serum when HIV antibody test on the same day is negative or indeterminate.
>
> Laboratory criteria for HIV infection are:
>
> - A positive result from an HIV antibody screening test (eg, reactive enzyme immunoassay) confirmed by a positive result from a supplemental HIV antibody test (eg, Western blot or indirect immunofluorescence assay); or
> - A positive result or report of a detectable quantity from any of the following HIV virologic tests: HIV DNA or RNA detection test (eg, polymerase chain reaction); HIV p24 antigen test, including neutralization assay; or HIV isolation (viral culture).
>
> Case classification for HIV infection stages is as follows:

- Stage 1: No AIDS-defining condition, and either CD4+ T-lymphocyte count greater than 500 cells/μL or CD4+ T-lymphocyte percentage of total lymphocytes higher than 29%.
- Stage 2: No AIDS-defining condition and either CD4+ T-lymphocyte count of 200 to 499 cells/μL or CD4+ T-lymphocyte percentage of total lymphocytes of 14% to 28%.
- Stage 3 (AIDS): Laboratory confirmation of HIV infection and CD4+ T-lymphocyte count of more than 200 cells/μL or CD4+ T-lymphocyte percentage of more than 14%, or documentation of an AIDS-defining condition (with laboratory confirmation of HIV infection).
- Stage unknown: Laboratory confirmation of HIV infection and absent data on CD4+ T-lymphocyte count or percentage and absent information on presence of AIDS-defining conditions.
  (Barclay, 2008, pp.1-2)

2.2.1. *U.S. Health Policies & HIV Prevalence*

U.S. health policies, programs, and HIV prevalence have historically been based on concerns about white heterosexual populations (Singer, et al. 1990). The HIV/AIDS epidemic is no exception. The U.S. government did not perceive HIV/AIDS to be a threat to society because it primarily impacted MSM and IDU. HIV prevalence rates among white non-IDU heterosexuals had not been discovered at the beginning of the epidemic and HIV/AIDS was perceived as a cleansing of social deviants. President Ronald Reagan failed to raise awareness in the U.S. until 1986, despite the advancement of knowledge in identifying HIV/AIDS and the mode of transmission of the virus during the early 1980's (AEGIS, 2005). A reporter was able to get President Reagan to mention AIDS in 1985, but the President did not make a formal announcement about the threat of HIV in society to congress until 1986 (AEGIS, 2005).

2.2.2. *HIV/AIDS Movement*

The HIV/AIDS pandemic has reached three decades since it was first discovered in 1981. The Kaiser Foundation (2004) drafted a timeline of historical milestones of

HIV/AIDS globally in the past 30 years (Appendix A). The HIV/AIDS movement provides critical insight into how power elite ideology reinforces social structures in protecting their interests and maintaining order in society. The President's lack of response towards the HIV/AIDS epidemic was no oversight. The white heterosexual community was not perceived as being at risk for HIV/AIDS even as infection rates began to grow in the heterosexual community among people of color. Cohen (1999) provides a comprehensive review of the influence that HIV/AIDS had in the black community.

An emphasis is made on how the power elite utilized social structures to perpetuate the perception of HIV/AIDS initially as a "gay white man's disease" and later as an injection drug use "curse" among people of color. Cohen's (1999) work demonstrates the implications of social stratification and how the power elite reinforce social structures to perpetuate inequality within historically oppressed populations. At the pinnacle of the power hierarchy were white dominant institutions (e.g., President, congress, CDC, media) that reinforced the image of white gay men as being at greatest risk of contracting HIV. These same institutions failed to acknowledge HIV prevalence rates among people of color that were IDUs at the start of the epidemic (Cohen, 1999). The black community and communities of color subsequently did not consider HIV/AIDS a threat due to the misconception that it affected only gay white men.

Social stratification within society sheds light on how gender, sexuality, and class are used to determine one's status. The HIV/AIDS epidemic gave greater visibility to gays, lesbians, MSM, and IDU in the black community. Black gay and lesbian activists were raising awareness of the needs of the black community at the start of the epidemic.

As funding became available to address HIV/AIDS in the black community, black institutions took control and further marginalized groups (i.e., gays, lesbians, MSM, IDU) that did not reinforce the ideology of the black middle class. As black conservatives replaced black gay and lesbian activists they also shifted the political agenda towards addressing HIV/AIDS in the black community. The original pioneers of the HIV/AIDS movement were LGBT activists. As funding increased for "high-risk" populations to provide culturally appropriate HIV/AIDS prevention and intervention programs, conservative gatekeepers/leaders of the black community imposed their ideology and gained control of funds allocated for programs and development. Black leaders and institutions distinguished between the deserving (e.g., women infected through heterosexual intercourse and children) from the undeserving (e.g., gays, lesbians, IDU, MSM). The obstacles put in place by white dominant institutions were reinforced through the leadership of people of color by indigenous institutions, which turned their backs on the most vulnerable (e.g., gays, lesbians, IDU, MSM). The lack of public health leadership and fragmented interests of the black community hindered their efforts to mobilize politically and prevent the spread of HIV/AIDS. Conservative ideology prevailed and the oppressed became the oppressors.

Cohen (1999) illustrates how enduring structures (e.g., economic, government, culture) enable and constrain the black community's responses to HIV/AIDS. The enduring structures dominated by the white power elite control major global and national trends, municipal level determinants, public health interventions, and urban living conditions (Freudenberg, Galea, & Vlahov, 2006). The structures also reinforce social

stratification within historically oppressed and highly marginalized populations, which allow limited access of power to a selected few such as the black and Latino elite.

Social and public health problems such as HIV/AIDS are conceptualized by the power elite, which utilize enduring structures to reinforce an intricate network to justify their actions in addressing a social problem. HIV/AIDS is not an isolated problem limited to the U.S. and policies influence funding allocation within the U.S. as well as abroad. The multiple layers (i.e., major global and national trends, municipal level determinants, public health interventions, urban living conditions) demonstrate how the ideology of the power elite and the dominant state (e.g., U.S.) influence initiatives addressing social problems in a foreign state (e.g., Brazil). Therefore, it is critical to develop an understanding of the American response as well as the implications it has for low and middle income states towards addressing a social problem.

Major global and national trends influence how health is perceived (Freudenberg, Galea, & Vlahov, 2006). Municipal level determinants are lower level governance structures (e.g., courts, schools, police, fire department) that take into consideration the role of the government, markets (e.g., food, housing, labor) and civil society (Freudenberg, Galea, & Vlahov, 2006). President Reagan decreased resources/programs for vulnerable and stigmatized populations (Cohen, 1999). Black conservatives were recruited to reinforce the political agenda of holding individual's responsible for reducing their own risk of HIV transmission (Cohen, 1999). The labor market gave rise to the black middle class which gained influential positions of power in the community (Cohen, 1999). The media market in turn limited information about the AIDS epidemic and focused more on the discomfort black leaders felt about "immoral" behavior among

MSM and IDUs (Cohen, 1999). The Down Low[1] (DL) phenomenon has been sensationalized by the media, which placed the blame on black MSM for increased HIV prevalence in the black community and disregarded the initial apathetic response from the government in preventing the spread of HIV. The power elite have placed an emphasis on who is better-suited to address a health crisis for people of color, which determines gatekeepers that will reinforce existing social structures and the power elite's ideology. The response to the HIV/AIDS crisis in the black community was mobilized by black gay and lesbian advocates who had a political agenda, which was replaced by the black elite's conservative focus on the middle class (Cohen, 1999).

Public health initiatives originally focused on gay white men, but as prevalence rates significantly increased among people of color, funds were provided for use by established indigenous institutions (Cohen, 1999). Cohen illustrates how social stratification and marginalization is reinforced in the black community, which results in vulnerable populations becoming dependent on the black elite to ensure that their needs are voiced and met (Cohen, 1999). Therefore, social capital and support is maintained among the black elite. The power elite's failure to address the HIV/AIDS epidemic resulted in disproportionate rates significantly impacting the black population.

Although Cohen places an emphasis on the black population, HIV/AIDS had the same impact in the Latino community. There have been limited efforts to raise greater awareness about HIV/AIDS within the Latino community. HIV/AIDS is regarded as a

[1] Denizet-Lewis (2003) published an article in The New York Times on black MSM living a heterosexual lifestyle, but having sexual encounters with men. DL black men identified as heterosexual and have female primary partners (e.g., wife, girlfriend), but they also maintained a secret life and had sexual encounters with other men. "…Down Low culture has come to the attention of alarmed public health officials, some of whom regard men on the DL as an infectious bridge spreading H.I.V. to unsuspecting wives and girlfriends (Denizet-Lewis 2003, p2)"

social problem by the power elite that evolved from a white gay disease to a black DL problem, portraying black men as predators maliciously infecting innocent vulnerable females, accompanied by IDU in communities of color. The literature demonstrates that by identifying scapegoats (e.g., gay white men, DL black men, IDUs of color) as the cause of the HIV epidemic, attention is diverted from the government's response to the community, and places the responsibility on the individual to reduce exposure to HIV, thereby, disregarding the influence that social structures have in exacerbating and addressing HIV in communities of color (among them, Latinos).

History repeats itself and Latinos initially believed that they were not at risk for HIV transmission because they might not have identified with the cultures of gay white men or DL black men, which is similar to what occurred at the start of the epidemic among black people not identifying with gay white men – [I {black person} don't have sex with a gay white man so I do not need to worry about HIV]! An emphasis in the following section will be placed on social stratification and the government's response to address and treat HIV/AIDS.

2.2.3. *Ryan White Comprehensive AIDS Resources Emergency (CARE) Act*

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was named after a white teenage male named Ryan White who died of AIDS in 1990. Ryan contracted the virus through a blood transfusion required for his hemophilia treatments. A significant amount of media attention focused on the stigma and discrimination Ryan faced in the community and school due to his AIDS diagnosis. Ryan and his family advocated for his right to attend school and raised awareness of HIV/AIDS. Ryan White's dire condition due to AIDS was the catalyst for members of the heterosexual

mainstream society to establish alliances with other groups advocating for the rights of marginalized populations (e.g., MSM, IDU, sex workers). Ryan became the new face of AIDS as the media raised awareness that mainstream society was also vulnerable and that HIV/AIDS was no longer limited to gay white men. Greater prevalence rates among white people at the start of the epidemic caused an increased investment to ensure that appropriate measures were taken by the government in addressing the needs of PLWHA, which resulted in the CARE Act.

In 1990 the government implemented the CARE Act to provide medical care, medication, and services for PLWHA (HRSA, 2005). The CARE Act is considered the "payer of last resort" for PLWHA who do not have access to health insurance, medical care, and/or services (HRSA, 2005). The Health Resources and Services Administration (HRSA, 2005) gives state and local programs complete control in determining how to better meet the needs of the population. Giving states the power to implement the CARE Act for the community has resulted in non-standardized eligibility requirements nationwide. Some states have been placing PLWHA on a waiting list and providing stringent guidelines for access to services. Although the CARE Act provides funding for planning councils to address health disparities among PLWHA, many communities of color, women, MSM, and IDUs living with HIV/AIDS still do not have access to health insurance, services, medications, and medical treatment (Mamo & Mueller, 2003; McInnes, et al. 2004; Parham & Conviser, 2002; Palepu, 2004).

The following statistics demonstrate how the HIV/AIDS epidemic has disproportionately affected historically oppressed populations and the significance it had on the government's response in reinforcing inequality in healthcare for PLWHA. The

number of AIDS cases by race/ethnicity and year of diagnosis (1985-2002) has decreased for whites while at the same time they have increased for Latinos and blacks (UNAIDS, 2004). An estimated 41,269 people were diagnosed with HIV in the 37 states in the U.S. during 2008[2]; 52% of the cases were among blacks, 29% were among whites, and 17% were among Latinos (CDC, 2010). California, which has a significant Latino population, is not included in the 37 states that report HIV infections to the CDC. California reported the highest number (4,835) of AIDS diagnoses in the nation for 2008 (CDC, 2010). At the end of 2008, 22,810 (40% black and 20% Latino) diagnoses of HIV infections were reported among MSM (CDC, 2010). An additional 1,173 (36% black and 21% Latino) were among male IDUs that had sexual encounters with other males (CDC, 2010).

The epidemic can no longer be seen as a problem of MSM and IDUs. In 2004 the epidemic started spreading significantly through heterosexual transmission among women of color (HRSA, 2005). Advances in medications for HIV have led to people living longer with the virus and has caused AIDS mortality rates to decline. Along with better quality of life for PLWHA came the demand for healthcare from people that did not have access to healthcare and medications.

Inequality among PLWHA is still pervasive despite advances made in medical treatments for HIV/AIDS. The new face of AIDS has changed the demographic of AIDS Drug Assistance Program (ADAP) clients, which is funded through the CARE Act. ADAP provides national funding so the states and U.S. territories can enhance healthcare

[2] The CDC does not obligate states to report HIV infections, but the CDC does request states to voluntarily report HIV infections. The following states require confidential name-based HIV infection reporting since at least January 2005: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

and services for PLWHA (HRSA, 2005). In 2004 ADAP clients throughout the U.S. were primarily people of color (e.g., 34% black, 26% Latino), men (79%), 25-44 years of age (57%), below the federal poverty line (80%), and uninsured (Kates, et al. 2005). Kates and colleagues (2005) indicated that there are 42-59% of PLWHA in the U.S. who were not receiving treatment for HIV/AIDS.

ADAP initiatives have been stringent in enrolling new clients since a significant number of PLWHA belong to historically oppressed groups such as blacks and Latinos. Decreasing prevalence rates among white men and greater access to resources (e.g., employment, health insurance, medical treatment) has resulted in a lack of interest among gay white men to advocate for issues affecting PLWHA. HIV positive white men are more likely to have private health insurance, greater educational attainment, better health, and receive Highly Active Anti-Retroviral Treatment (HAART) (Bhattacharya, et al. 2003). The disease has become a chronic, yet manageable problem for them.

Men receiving public insurance were found to have an increased probability of one-year mortality (Bhattacharya, et al. 2003). Men with private insurance (50%) are more likely to receive HAART treatment by first follow-up compared to 34% publically insured and 32% of uninsured men (Bhattacharya, et al. 2003). Historically oppressed and highly marginalized populations are more likely to be uninsured or rely on publicly insured health programs. Being uninsured or insufficiently insured is associated with a progression of HIV to AIDS and increased mortality (Bhattacharya, et al. 2003).

The government has made several attempts to address the HIV/AIDS epidemic among people of color over the past 10 years, but the epidemic continues to spread. Interventions have been largely unsuccessful in addressing the needs of Latinos and

blacks. The Minority AIDS Initiative (MAI) in 2000 placed an emphasis on efforts to address the epidemic among people of color. The CDC designated a goal in 2001 to cut HIV prevalence rates in half by 2005 (AVERT, 2006). The government also supported a faith-based initiative in 2001, which cut funding for AIDS Service Organizations (ASO) and placed a stronger emphasis on abstinence-only programs. The CDC realized in 2003 that stronger actions were needed and launched the Advancing HIV Prevention (AHP) initiative to provide greater access to healthcare for PLWHA (CDC, 2004). Overall, funding in the past decade has been conservative despite increasing HIV/AIDS prevalence rates among people of color.

Summary

The power elite have perceived homosexuality as a threat to their beliefs and values. The literature shows how homosexuality has been perceived as a social problem. Religious ideology has historically condemned homosexuality, which resulted in murders of known homosexuals as early as the Middle Ages. Religious leaders taught that the sole purpose of sexual intercourse was procreation. They also emphasized traditional male roles as heads of households and providers for their families. Males that deviated from traditional gender norms (e.g., males "acting" and/or instilling effeminate traits) threatened the existing patriarchal structure. The power elite was unable to accept people that deviated from prescribed social scripts, which resulted in the identification of homosexuality as a pathology to maintain order and reinforce consequences for people that deviated from the norm.

Stonewall became the impetus for the gay liberation movement. People that were GLBT had enough of the physical and verbal harassment they encountered from authority

figures (e.g., police) and began to rebel. The gay liberation movement became a venue where GLBT people could organize and address inequality. One result of this movement was the removal of homosexuality from the DSM. Removal of homosexuality from the DSM and the economic boom were significant factors in allowing the GLBT community to prosper. The HIV/AIDS epidemic in the U.S. demonstrates the unwillingness of the power elite (e.g., President, government) to address the health epidemic until it affected the white heterosexual community. The HIV/AIDS epidemic demonstrates the implications of social stratification and determination by the power elite to enact measures for protecting their interests. The government responded once it became evident that HIV was starting to spread among the white heterosexual population.

3. Theoretical Analysis

Power Elite Theory will be applied to the evolution of the HIV/AIDS epidemic as a social problem and focus on the implications the epidemic has had among historically oppressed and highly marginalized populations. This theoretical section will describe social structures in greater detail to provide a better understanding of how power and status are maintained by the power elite. The literature demonstrates how social structures (e.g., government, religious institutions) have perceived and responded to the HIV/AIDS epidemic.

According to power elite theory the government's response to the epidemic was influenced by which communities were affected. The initial belief that AIDS was a gay-related disease among white men caused the government to delay responding to the epidemic. The power elite thought that the HIV/AIDS epidemic would cleanse society of sexual deviants; a perception which was also reinforced through religious rhetoric emphasizing that homosexual behavior is an abomination. Despite stigmas reinforced by the power elite (e.g., government, religious institutions) gay white men's racial status provided them access to resources (e.g., education, money, social contacts) that allowed them to mobilize and advocate for resources addressing HIV/AIDS. Power elite theory and queer theory are used in this study to demonstrate how power and status by the power elite is reinforced through social stratification, which is determined by multiple factors (e.g., race, gender, socioeconomic status, sexuality) that reinforce inequality.

Queer theory adds breadth to the ways in which social problems (i.e., HIV/AIDS, homosexuality) are perceived by the power elite. Queer theory places an emphasis on the power elite's reinforcement of a patriarchic structure through language and the

application of methods to oppress "social deviants." An overview of social stratification illustrates how the power elite designate roles of authority that reinforce inequality in society. For example, the social response to HIV/AIDS changed as the epidemic evolved from gay white men to people of color. The racial shift of the epidemic from white to people of color demonstrates how power and status influence society's response to a social problem and what the implications are for accessing resources.

3.1. *Power Elite Theory*

> The power elite is composed of men [and women] whose positions enable them to transcend the ordinary environments of ordinary men and women; they are in positions to make decisions having major consequences. (Mills, 1956, pp.3-4)

Power elite theory states that there is a concentrated small group of powerful men and women that determine what is best for a society and enforces social structures to maintain their power and "civilize" society. Mills (1956) believed that power is not solitary, but it is composed of an intricate hierarchy that is put in place to dominate society. At the pinnacle of the hierarchy are the power elite, which is made up of people who have access to the most money, power, and prestige in society. The second level of power is composed of professional politicians and pressure groups, which are primarily from the new and old upper classes (Mills, 1956). The subsequent levels consist of social structures such as the economy, political order, military, religious institutions, academic institutions, police, and families. The social masses are concentrated at the bottom of the hierarchy.

A social structure is defined as an institution or group of people with designated beliefs and values that influence behavior within their social network. The government responded to the HIV/AIDS epidemic, for example by emphasizing a cognitive-

behavioral approach for educating individuals about HIV/AIDS transmission. This approach has caused the power elite (e.g., CDC, funders) to diffuse evidence-based HIV/AIDS prevention interventions as an effort to enhance capacity of service providers in reducing the spread of HIV. Focus on the individual reinforces the belief that one is entirely in control of one's destiny, unencumbered by social constraints and structures. This perspective reinforces beliefs in the dominant society such as: if MSM would live a *respectable* lifestyle (e.g., monogamous relationship, married) they would not have to worry about HIV/AIDS. Empathy towards PLWHA is determined by the mode of transmission, which garners access to resources. For example, people may feel more empathy for a married female who was infected by her husband, who did not disclose his infidelity with other males and/or females.

Mills (1956) states that power is centralized in a *triangle of power* made up of three dominant institutions (i.e., economy, political order, military). The economy is composed of dominant corporations (e.g., pharmaceutical companies, CDC) that make influential decisions which have significant consequences for the nation's economy (Mills, 1956). The U.S. economy is no longer isolated; it has become a competitive global market.[3] The U.S. dominates five of the top ten globally ranked companies: General Electric; Exxon Mobil; AT&T; Wal-Mart; and Chevron (Forbes, 2009).

The trickle-down effect allows the power elite to allocate funding for designated *worthy causes* through corporate giving and private foundations. Children are usually perceived as a *worthy cause*, for example, due to their dependence on adults to ensure a healthy quality of life. Adults on the other hand are perceived as capable of determining

[3] The top world billionaires are Carlos Slim Helú ($53.5 billion) from Mexico followed by William Gates III ($53 billion) and Warren Buffet ($47 billion) from the U.S. (Forbes, 2010).

what is in their best interest. The power elite places an emphasis on protecting their interests and charitable donations are seen as strategic investments in maintaining their control. Carlos Slim Helú, a person of color, is an example of being the wealthiest man in the world, yet he still reinforces social inequality through structures that capitalize from society. Mr. Helú exemplifies the role of a gatekeeper; someone who has gained power and wealth to serve his own interests. Paulo Freire's work is discussed in this chapter to clarify how oppression becomes a dysfunctional cycle even within historically oppressed groups when they gain access to power and become bigger tyrants than their oppressor.

The power elite in the U.S., for example, reinforce the belief that Latinos are foreigners who steal resources (e.g., education, healthcare, employment) from Americans. Many Americans blame Latinos for the economic recession. Latinos become the scapegoats by taking the focus away from the power elite who have escalating profits despite the recession. Therefore, lack of credible Latino representation among the power elite limits dissemination of resources for resolving social problems among Latinos.

The political order is a centralized structure of the *triangle of power* that designates policies throughout the nation. Health insurance companies for example have a preexisting health condition clause which allows them the right to refuse healthcare for PLWHA if they have not received treatment in the six months prior to enrollment. The political system has historically supported health insurance companies, but President Obama's Health Reform Act banned health insurance companies from denying health insurance to people with pre-existing health conditions including HIV/AIDS. The Act,

which was enacted in 2010 for youth under 19 years of age and it will be enacted in 2014 for adults 20 years of age and older.

The military order is also a component of the *triangle of power* and a significant force of government (refer to Appendix B: Table 1) and the U.S. has prioritized discretionary spending for the military. The power elite have invested 657 billion dollars in the military compared with 57 billion dollars in healthcare. This disparity is indicative of the power elite protecting its assets and limiting investments in larger society that ensure services such as education, healthcare, housing, employment, and social services.

The military historically has frowned upon homosexual behavior. Article 93 was enacted in 1917 to prohibit sodomy. The U.S. Department of Defense (DoD, 2010) states:

> After World War II, in October 1949, the Department of Defense issued a memorandum that standardized policy across Services. This policy stated that "homosexual personnel, irrespective of sex, should not be permitted to serve in any branch of the Armed Services in any capacity, and prompt separation of known homosexuals from the Armed Forces be made mandatory." (p.20)

The DoD (2010) stigmatized homosexuals as "sexual perverts" using this as a reason to discharge people from military service during the 1950s. In 1975 the term was changed and discharges were reported due to "homosexual act or other aberrant sexual tendencies" (DoD 2010, p.20). Several lawsuits were filed against the DoD due to inconsistent discharges based on homosexuality, which caused another policy revision in 1981 that personnel could be discharged only if they were openly gay or lesbian (DoD, 2010). The DoD believed that homosexuality would "seriously [impair] the accomplishment of the military mission" (DoD 2010, p.21). Prior to 1981, the DoD believed that homosexuality weakened individuals' physical and/or mental state and their ability to perform at the

same level as other military personnel. After 1981 the DoD perceived homosexuals as a threat to other military personnel (DoD, 2010). The DoD (2010) once again revised the policy in 1982 citing the following grounds for dismissal based on homosexuality:

1) a statement that one was gay;
2) engaging or attempting to engage in homosexual acts;
3) marriage to a person of the same sex.
(p.21)

A reassessment conducted by a Military Working Group in 1993 indicated that inconsistencies still remained despite revisions made to policies regarding homosexuals in the military (DoD, 2010). Litigation caused the Clinton administration to revise policies on homosexuality and in 1993 implemented "Don't Ask, Don't Tell, and Don't Pursue" (DADT), which thwarted further investigations on arbitrary homosexuality charges against military personnel (DoD, 2010). The assessment also determined that military life was not comparable to civilian life due to lack of privacy and freedom to determine living and work conditions (DoD, 2010). This lack of civilian rights reinforced prohibitions against homosexuality in the military. The inconsistencies between the DoD and the government policies on homosexuality caused the Obama administration to arrange a further investigation in March 2010 regarding the policy and its implications for the armed forces. The comprehensive review indicated that military personnel acknowledged homosexuals in the military despite policies regarding the prohibition of homosexuality in the military (DoD, 2010).

Military personnel were concerned with dissemination of existing resources that the military provided to personnel and their wives and husbands. They struggled with the issue of how the military would assess benefits for partners of homosexual military personnel when the U.S. government did not legally recognize same sex marriage.

Heterosexuals expressed concern for differential treatment based on sexuality by granting homosexual partners access to benefits and denying heterosexual partners access to benefits unless they were married. Heterosexuals who have unmarried partners would not have the same access to resources that would be given to same-sex homosexual partners. Marriage entitles heterosexual partners to access their partner's military benefits, but benefits are not extended to unmarried partners. Heterosexual married couples also have greater access to resources in society (e.g., tax cuts, power of attorney) than homosexual couples. The argument among military personnel is based on their heterosexual entitlement and the direct implications benefits for homosexuals may have for them as opposed to historically oppressed groups (i.e., homosexuals).

The Obama administration made a significant step forward in December 2010 when it announced the repeal of DADT. The administration's comprehensive review indicated that the majority of military personnel did not support DADT (DoD, 2010). The overall results showed that:70% reported that working together to get the job done would have a positive, mixed, or no effect; 69% reported that they worked with a co-worker that they believed to be homosexual; and 92% reported that the unit's ability to work together was very good, good, or neither good nor poor.

People who supported DADT emphasized religious rhetoric prohibiting homosexuality and stigmatized homosexuals as sexual deviants with an inability to control their sexual behaviors. The findings demonstrated a significant sense of entitlement among the dominant group (i.e., heterosexuals), and an expectation that the minority group (i.e., homosexuals) would subscribe to beliefs and values that supported a "moral" environment reinforcing a heterosexual patriarchy of family values. Religious

ideology reinforced the core disciplines of the armed forces. A participant stated (DoD 2010):

> The problem is dealing with people's background or moral teachings and there are a percentage of Marines who have religious basis for being against homosexuality, and you cannot ask or force people to go against something that they have been taught. (p.52)

Homosexuality was also synonymous with AIDS and some military personnel were concerned about the rampant spread of HIV in the general population. The spread of HIV/AIDS does warrant attention among military personnel, but an emphasis must be placed on the modes of HIV transmission and susceptibility to transmission regardless of sexuality. Heterosexual men that are IDUs and/or solicit sex from CSWs also increase their risks of HIV infection. A participant asked (DoD 2010, p.54): "If you are in an infantry company in a fire fight, and you have an open homosexual who gets wounded, who is going to want to treat him for the fear of HIV and other stuff?" The DoD (1991) also has an existing protocol for policies and procedures to be updated on issues related to military personnel infected with HIV-1. The DoD would have to conduct an overview of the procedures and educate military personnel on the modes of HIV transmission and emphasize that everyone, regardless of sexual orientation, is at risk of HIV transmission and universal precautions must be taken when exposed to blood, semen, and/or vaginal fluids.

A focus on the DoD is critical to further emphasize how power is centralized within the *triangle of power* towards reinforcing a heterosexual patriarchal structure. The DoD was able to "justify" discriminating against homosexuals and discharging them from the military prior to December 2010 despite government policies stating that it was illegal to discriminate based on sexual orientation.

As the literature indicates there is an extensive list of characters within the hierarchy of power, but a review will be made on a more generalized list of characters (e.g., power elite, celebrities, general society) for the sake of this research study. The 21st century has seen significant strides in changing the demographics of the hierarchy of power. Historically the power elite of the *triangle of power* have been white men due to their historical influence on the colonization of the Americas, but history was made when the first black U.S. President Barack Obama was inaugurated into the White House in January 2009. Although President Obama's arrival in the White House was a significant step for a nation that has historically maintained a white power elite, but it does not mean that the struggles of historically oppressed populations have ended.

3.1.1. *Inequality & the Triangle of Power*

The structures of the *triangle of power* reinforce one another. The top of the power elite paradigm still consists of predominantly white men who determine what and how resources will be disseminated. Inequality among historically oppressed populations is still pervasive, despite a limited number of people of color being in influential positions. President Obama made strides by electing Judge Sonia Sotomayor as the first Latina into a highly coveted position in the Supreme Court, but there is still a significant lack of representation by people of color in the U.S. government. Judge Sotomayor's position in the Supreme Court provides a sense of false hope for Latinos. The media has emphasized Judge Sotomayor's social status climb into an elite group by overcoming the significant odds of being raised in a single female-headed household in poverty to a position in the Supreme Court. Racism, inequality, and oppression have now come to be regarded as no excuse for one's (i.e., people of color) predicament because history was

made in the U.S. by electing the first black president and Latina judge in the Supreme Court. The power elite will use them as examples for historically oppressed populations to be held accountable for their actions, which extends to their well-being in remaining HIV negative. What is apparent is that with the "admission" of a few blacks and people of color into the power elite *triangle*, the belief that people can and should "pull themselves up by their bootstraps" continues to be extended to individuals in protecting themselves from HIV infection.

Celebrities, the next level of characters below the power elite are generally politicians and wealthy (old and new money) people. Mills (1956) states:

> …celebrities are not at the head of any dominating hierarchy, they do often have the power to distract the attention of the public or afford sensations to the masses, or, more directly, to gain the ear of those who occupy the positions of direct power. (p.4)

Celebrities are spokespersons for the elite and their status is dependent on the publicity and entertainment industry (Mills, 1956). Latino celebrities have historically been portrayed as white Americans and have changed their names (e.g., Linda Carter) to become more marketable and maintain lucrative careers. In 2007, Jessica Alba denied her identity as a Latina and emphasized her American heritage, despite being of Mexican descent. Stereotyping images personified by celebrities uphold social stigmas (e.g., drug dealers, gang bangers, uneducated, undocumented), which may lead to greater obstacles for Latinos pursuing an education and/or career. Latino celebrities with strong *ethnic* phenotypic features are typecast to reinforce the stereotypes. The media perpetuates a dysfunctional cycle of inequality by portraying "white" Latinos as successful role models and *ethnic* Latinos as delinquents. White Latinos develop a sense of privilege and

entitlement and *ethnic* Latinos develop a sense of oppression and struggle, which affects their trajectory in life and susceptibility to HIV transmission.

Rodriguez (2009) sheds light on the Latino film industry and the influence Latinos have in addressing Latino stereotypes through film, but also discusses the influence that power elite ideology has on access to resources for film production. Rodriguez (2009) emphasizes:

> While Chicano media makers may adhere to cultural nationalist plans of action (such as "El Plan," for example) to direct "the people" toward common goals, they are also forced to maneuver within – and often times conform to mainstream institutions (i.e., Hollywood) and dominant ideologies in the United States if they desire access to technology, funding, mass distribution, and a wider array of spectators. (pp.67-68)

Chicano film makers may have a political agenda, but they must maintain a fine balance between telling "their" story and relating it to mainstream society; hence the struggle between white and *ethnic* Latino typecasting. Xenophobic attitudes are used to remind viewers that despite commonalities between their cultures (e.g., white, Mexican) Latino *deviants* (e.g., gang bangers, drug dealer, undocumented immigrant) set them apart from civilized white middle class families (Rodriguez, 2009). Latino film makers become the gatekeepers in determining the story and portrayal of Latinos to mainstream society. Rodriguez (2009) further states:

> While I do not want to insist that Chicanos must necessarily work outside of Hollywood in order to produce more authentic or true-to-life Chicano and Latino images, it is common knowledge that minority filmmakers – when working within "White spaces" and in contact with "White power" – are always forced to negotiate with the terms established by the film industry. (p.73)

Rodriguez (2009) sheds significant insight into the film industry and demonstrates the dynamics of power and status between a dominant group (i.e., white men) and an

oppressed group (e.g., Chicanos). The power elite also utilize celebrities as spokespeople for social causes that the power elite perceive as "worthy." These social causes enhance or jeopardize a celebrity's career. Ricky Martin is an example of a Latino celebrity who at first portrayed himself as a heterosexual due to the constraints of the entertainment industry, until he announced that he was gay in 2010. Prior to disclosing his homosexuality, Ricky Martin used his celebrity status to advocate for the human rights of children. The power elite always perceive children as a worthy cause without speculation. Ricky Martin's portrayal of himself as a heterosexual could have been jeopardized if he supported social causes such as HIV/AIDS awareness campaigns that may have led to speculation about his sexuality. Society is influenced by celebrities and if they do not promote awareness of a social issue the issue becomes "out of sight out of mind" for the public. The current lack of celebrity public service announcements focused on HIV/AIDS in the Latino community provides a false sense among Latinos that they are not at risk for HIV transmission.

3.1.2. *Latinos & Social Stratification*

Latinos currently are the largest population of color in the U.S., but they do not share the same proportion of the economy. Among people of color it is also important to note the significant accomplishments of black celebrities as well and the implications for HIV/AIDS. Forbes (2010) has ranked Oprah as the most powerful celebrity in part due to her earning $315 million. Beyonce Knowles was ranked as the 11th highest paid ($87 million) celebrity (Forbes, 2010), but the 2nd most powerful celebrity due to her combined rank of power (income, TV/radio, press, web, and social). Although Oprah and Beyonce wield tremendous power they have placed little emphasis on the HIV/AIDS

epidemic in the U.S. despite the fact that black Americans suffer the highest HIV prevalence rates. Oprah has utilized her talk show as a platform to raise awareness of the epidemic, but she has also stigmatized black MSM on the "down low" as malicious predators infecting helpless females. The portrayal of black MSM on the down low placed the blame for the HIV/AIDS epidemic on a highly marginalized population instead of focusing on the government's response at the start of the epidemic and what actions one can take to reduce the risk of HIV transmission.

Celebrities play an important role in entertaining the masses during difficult times such as an economic recession, but they also have a significant responsibility to address social causes such as HIV/AIDS in the community. The world of celebrities provides society an affordable sense of escape from one's problems and it reinforces one's ambitions to become rich and successful, which is demonstrated through material goods.

> Money is the measure of all things, and profit the primary goal. For the oppressors, what is worthwhile is to have more – always more – even at the cost of the oppressed having less or having nothing. For them, *to be is to have* and to be the class of the "haves." (Freire, 1970, p.58)

A capitalist society reinforces this mindset and leads to judging others' value based on their accumulation of material goods. The American drive to obtain more wealth and a luxurious lifestyle reinforces the need to focus on individual needs at the expense of others. Historically oppressed populations (e.g., Latinos) become key players in reinforcing a capitalist system, which demonizes social welfare as a handout to the undeserving. The hierarchy of power creates multiple layers of power (i.e., social stratification) to reinforce acceptable and unacceptable norms in society. Celebrities reinforce social norms in movies and television by demonstrating consequences of one's actions. The power elite pays celebrities inflated salaries to reinforce existing social

structures and become spokespersons through the media for causes designated as worthy by the power elite and people in the industry that do not reinforce the system usually do not gain status as a celebrity. The power elite and gate keepers are in coveted positions to approve or disapprove what gets promoted in the media (e.g., television, radio, film, newspapers), which influences society's beliefs and values. "More and more, the oppressors are using science and technology as unquestionably powerful instruments for their purpose: the maintenance of the oppressive order through manipulation and repression" (Freire, 1970, p.60). Social norm and beliefs are reinforced by the power elite to ensure order in society.

The power elite create an ideology made up of norms and values that provide social scripts for society to reinforce social structures through culture (Portes, 2006). The power elite for example have reinforced *machismo* and *marianismo* as social scripts for Latino males and females to reinforce. *Machismo* reinforces the role of males as sexually aggressive and violent in their pursuit of conquest. *Marianismo* reinforces the counterpart of the male role portraying females as docile, fragile, and unable to communicate or advocate for their rights. These extreme hyper-masculine and hyper-feminine social scripts reinforce Latinos perceived incapacity to negotiate safer sex during sexual encounters and maintains the role of "experts" in educating people about social problems affecting historically oppressed populations.

Gatekeepers (e.g., religious leaders, teachers, politicians) are also authority figures in the hierarchy of power. These gatekeepers include people of color, who reinforce social norms and subjugate "deviants." Gatekeepers play a significant role in society because they perpetuate the dysfunctional cycle of oppression within their

communities. In order for power to be sustainable in society it must be reinforced through various organizations such as family, religion, schools, and economy (Portes, 2006). Gatekeepers reward people that reinforce social norms and punish people that deviate from social norms.

Colonialism in the Americas has strongly influenced power and status among Latinos, which is currently reinforced by gatekeepers. Cope (1994) demonstrates how social stratification occurred among Latinos during the colonization of the Americas:

> The Spanish, it is said, successfully propagated their ideology of racial hierarchy – a ranked series of categories, known as the *sistema de castas*, that placed the Spaniards themselves (naturally) on top, castas in the middle, and Indians and Africans at the bottom. Lower-ranking groups, acknowledging their position in the hierarchy, shaped their behavior accordingly. Ambitious castas, for example, scorned their inferiors and sought to marry "up" (into lighter-skinned groups). Racial ideology functioned as a system of control, since it created status differences between groups (such as blacks and mulattoes) who might have otherwise united against their oppressors. For confirmation of these assertions, one need only look at the actual socioeconomic structure of urban society. The Spanish monopolized political power and dominated the elite occupations, thereby enjoying a grossly disproportionate share of Mexico's wealth. In contrast, Indians, Africans, and mixed-bloods languished in low-paying, low-prestige positions. (p.4)

The role of gatekeepers reinforces dominion over the masses and dissemination of resources addressing the needs of society, which played a critical role in the colonization of the Americas. Social stratification among Mexicans dates back to the 1500s when the Spanish implemented a hierarchy of *castas* to determine one's social status based on ancestry during the colonization of Mexico. At the pinnacle of the hierarchy was pure Spanish (European) ancestry followed by Mestizo (Spanish and Indian ancestry), then Indian ancestry with African ancestry at the bottom. Despite the Spanish colonization of Mexico many Indian enclaves reinforced social boundaries and maintained their ethnic

identity during the colonization period, which was reinforced by royal policies that protected native communities (Cope, 1994). The preservation of social boundaries caused Spanish colonizers on the coast to import African slaves to meet their labor demands and maintain the land, which resulted in the arrival of 36,500 slaves into Mexico (Cope, 1994). Cope (1994, p.13) states: "At the height of the African influx, black slaves comprised less than 15% of the labor force in Mexico's major mining centers." A historical emphasis needs to be placed on the African slaves brought into Mexico due to the hierarchy of *castas* which placed blacks at the bottom; the most oppressed population in Mexico, and arguably throughout the Americas. As Cope (1994) states:

> In sixteenth-century Spain, "the adjective *negro* was often a synonym for evil," and blacks "were believed to be loyal, superstitious, light-hearted, of low mentality, and distinctly in need of white supervision." Spanish distrust and fear of blacks intensified in Mexico, where blacks constituted a much more important minority than they did in Spain. By the early 1570s, blacks formed by far the largest part of the castas, outnumbering mestizos by more than eight to one. (p.17)

The system of *castas* was elaborated due to the complex racial mixing. The system of *castas* depended on various factors (e.g., class, race, gender, education, social ties) that determined one's status in society. People who fit the colonial ideal of lighter skin, colored eyes (e.g., green, blue), "European" features, and blonde hair had greater access to power in Mexican society. This colonialist mentality has been internalized by Latinos. Latino families still value European phenotypic features and frown upon features associated with Indian and/or African ancestry. European phenotypic features continue to provide white privilege in Mexico, which demands a greater level of respect and authority in society despite their educational and/or socioeconomic status. Indians in

Mexico are still perceived as naïve and in need of guidance. White privilege among Mexicans occurs in the U.S. as well, which facilitates the process of acculturation. For example, Mexicans that pass for white do not encounter as many systematic obstacles of oppression as a Mexican with strong indigenous phenotypic features. Hence, the social stratification within a historically oppressed population (i.e. Mexicans) is reinforced through a neocolonialist subconscious mentality of white dominion. Latinos (e.g., Jessica Alba) attempt to convince the power elite that they are just like white people, therefore they should be regarded as the exception. Freire (1970) states:

> But almost always, during the initial stage of struggle the oppressed, instead of striving for liberation, tend themselves to become oppressors, or "sub-oppressors." The very structure of their thought has been conditioned by the contradictions of the concrete, existential situation by which they were shaped. Their ideal is to be men; but for them, to be men is to be oppressors. This is their model of humanity. This phenomenon derives from the fact that the oppressed, at a certain moment of their existential experience, adopt an attitude of "adhesion" to the oppressor. (p.45)

Freire (1970) introduces the concept of *prescription,* where the oppressed model the behavior of the oppressor in order to gain access to power and resources. A dysfunctional relationship develops between the oppressed with the oppressor and the oppressed begins to internalize social scripts of the oppressor, which causes the oppressed to transition identification from an oppressed group to an individualistic identity as an approach to accomplish their means (Freire, 1970). The more obedient the oppressed individual becomes in reinforcing expectations of the oppressor, the greater power he receives in society (Freire, 1970). Oppression of highly marginalized populations (e.g., homosexuals, IDUs, CSWs) by a historically oppressed population such as Latinos demonstrates to the oppressor that they (the oppressed) are just as civil as them (the oppressor) and they will not tolerate "deviants" (e.g., homosexuals, IDUs, and

CSWs) in society. Freire (1970, p.46) states: "It is a rare peasant who, once "promoted" to overseer, does not become more of a tyrant towards his former comrades than the owner himself." Hence, the power elite granting status to historically oppressed populations to act as authority figures/gatekeepers in reinforcing the "status quo" reinforces the hierarchy of the power elite.

> In their alienation, the oppressed want at any cost to resemble the oppressors, to imitate them, to follow them. This phenomenon is especially prevalent in the middle-class oppressed, who yearn to be equal to the "eminent" men and women of the upper class. (Freire, 1970, p.62)

A common misconception is that a historically oppressed person in authority will advocate for the best interest of their community, but the ambition to obtain greater power and status may result in greater subjugation of their historically oppressed comrades. "Any situation in which "A" objectively exploits "B" or hinders his and her pursuit of self-affirmation as a responsible person is one of oppression" (Freire, 1970, p.55). People become dependent on the *triangle of power,* which hinders their ability to pursue self-affirmation. Therefore, a comparison of historically oppressed and highly marginalized populations in Brazil and the U.S. demonstrates how power and status influenced a movement by the masses to ensure human rights for everyone.

3.1.3. *Social Climate & a State's Response to HIV/AIDS*

A significant contrast in response to the HIV/AIDS epidemic between Brazil and the U.S. was that the U.S. had an established political and economic structure, which resulted in an established middle class. Brazil's transition from a dictatorship to a democratic society provided the opportunity for a mass social movement because they had little to lose and everything to gain. The U.S. had an extremely well-established middle class during the start of the HIV/AIDS epidemic with an established democratic

political and economic system. Middle class Americans had sustainable resources (e.g., employment, health care, safety) that met their basic needs, but the lack of dependable resources among Brazilians became the impetus for mobilizing against the government. As a social movement, Brazilians were able to "disarm" the gatekeepers and in fact co-opted them.

The U.S. power elite is intent on maintaining the fine balance and distributes just enough resources to keep society complacent. Freire (1970) states:

> This is because welfare programs as instruments of manipulation ultimately serve the end of conquest. They act as an anesthetic, distracting the oppressed from the true causes of their problems and from the concrete solution of these problems. They splinter the oppressed into groups of individuals hoping to get a few more benefits for themselves. (p.152)

The power elite create a sustainable culture for people to obey authority figures. The process begins with children being taught through a *banking* educational approach, which requires students to listen and not question the teacher. A clear *prescribed* role is created for the pupil to memorize without questioning the knowledge dictated by the teacher. Freire (1970) indicates that the teacher is the source of knowledge in the *banking system* of education and the student is perceived as ignorant, which creates an ideology of oppression. The *banking* educational approach is unidirectional and obstructs dialogue where the student integrates his/her lived experience and contributes towards the knowledge process (Freire, 1970). Freire (1970) believed that the students and teacher educated each other.

The *banking* process is perpetuated throughout life to reinforce social structures. HIV interventions in the U.S. are a perfect example of the *banking* process where "experts" develop an effective intervention for a specific population, and then replicate

them with other populations without bringing those people into the discussion or allowing them to share their knowledge and experience. HIV interventions that were effective in stabilizing HIV prevalence rates among gay white men were not entirely effective in addressing the needs of people of color, thereby resulting in disproportionate HIV prevalence rates.

The economic recession for example has resulted in the government (e.g., CDC) claiming that it is providing society with the tools (e.g., Diffusion of Effective Behavioral Interventions) for addressing the HIV/AIDS epidemic, but greater accountability needs to be taken by the communities to ensure their own well-being. The CDC is currently making a big push for evidence-based research interventions addressing HIV/AIDS, but a significant problem that communities of color are encountering is that the research intervention needs further development to appropriately address the needs of their target populations.

Another issue that has been raised by providers and the community is the lack of people of color in leadership roles as principal investigators in research studies. A recent study (Ginther et al., 2011) reported that black researchers were one-third less likely than white researchers to obtain a research grant from the National Institute of Health, but Latino researchers were found to be comparable to white researchers in their receipt of NIH grants. Greater initiatives need to be taken by academic institutions to recruit faculty of color to enhance research initiatives among historically oppressed and highly marginalized populations. Racial disparities in academia and research increase limitations on research initiatives among people of color and the subsequent curtailment

of HIV transmission in the community that may come about as a result of HIV interventions developed by and with people of color.

A significant role of the *triangle of power* is to reinforce religious, educational, and family institutions in order to harness that power for the power elite (Mills, 1956). An interlocking system is created where the power elite determine what actions need to be taken and resources trickle down to the masses. Authority figures become aware of their prescribed roles within the hierarchy of power, which establishes social scripts between people (e.g., student, client) and the authority figure (e.g., teacher, researcher). The economy and political order for example influence educational institutions to train pupils in specialized skills for jobs to legitimize power.

> Religious, educational, and family institutions are not autonomous centers of national power; on the contrary, these decentralized areas are increasingly shaped by the big three, in which developments of decisive and immediate consequences now occur. (Mills, 1956, p.6)

Religious institutions play an integral role in the colonization of society. As Césaire (1972) states:

> …the chief culprit in this domain is Christian pedantry, which laid down the dishonest equations Christianity = civilization, paganism = savagery, from which there could not but ensue abominable colonialist and racist consequences, whose victims were to be the Indians, the Yellow peoples, and the Negroes. (p.33)

Spain's colonization of the Americas used Christianity to control and "save" the *savage* indigenous populations (Césaire, 1972, p.41). Césaire (1972) states:

> …the colonizer, who in order to ease his conscience gets into the habit of seeing the other man as an animal, accustoms himself to treating him like *an animal*, and tends objectively to transform *himself* into an animal. (p.41)

Domination and submission is seen as a form of salvation of the *savage*. Karl Marx's insightful statement that religion is opium for the masses captures the tension between the power of the church and patronage of society. Despite the source of guilt that is instilled by religious institutions, people still depend on religion to repent for forgiveness of their sins. Christianity uses religious rhetoric to justify colonialism and instills Christian moral values as an internal mechanism to guide the behavior of the people towards a more *civilized* society.

> I am talking about millions of men whom fear has been cunningly instilled, who have been taught to have an inferiority complex, to tremble, kneel, despair, and behave as flunkeys. (Césaire, 1972, p.43)

The implications of colonialism still persist. The power elite in the Americas remain as predominantly white men and women. Mills (1956) emphasized that one must assess the present state of the roles that the power elite play within the social structures of dominance. The power elite deem themselves worthy of their possessions and believe they posses a higher moral character that entitles them to rule over the masses (Mills, 1956). Mills (1956) indicated that the understanding of the power elite is found in the following three principles: 1) They perceive themselves as an elitist class of men of similar origin and education; 2) They maintain a cohesive psychological mindset to reinforce their interests; and 3) They reinforce a social milieu to enhance their control over the masses. A culture is created and reinforced by the power elite to exclude the masses and foster a close niche to maintain power and status. An example of this is the U.S, higher educational system. Ivy League educational institutions pride themselves in recruiting only the best faculty to prepare the next wave of leaders. Educational institutions provide an opportunity for students to rub elbows with the crème de la crème,

but even among Ivy League pupils the power elite perceive themselves of a different caliber to exclude outsiders. Forbes (2010) reported that Harvard was the top university to produce the most billionaires. An overall emphasis is placed on how power is harnessed as well as disseminated among the masses.

Despite significant strides in the diversification of people in power (e.g., President Obama, Judge Sotomayor, Oprah, Beyonce) historically oppressed and highly marginalized populations are poorly represented among the power elite. The power elite allow a limited number of historically oppressed and highly marginalized populations into influential positions to give a false impression of equality. The power elite emphasize that access to resources and power is attainable by anyone with a hard work ethic. The people of color who escaped poverty and gained entrance to the upper class reinforce the status quo. They become tokens of the power elite to maintain control over the masses and reinforce social scripts to ensure order in society. The following section will emphasize queer theory and provide an enhanced perspective of how power and status influences the subjugation of homosexuals through a patriarchic structure.

3.2. *Queer Theory*

> Ideologies are closely linked to power, because the nature of the ideological assumptions embedded in particular conventions, and so the nature of those conventions themselves, depends on the power relations which underlie the conventions; and because they are a means of legitimizing existing social relations and differences of power, simply through the recurrence of ordinary, familiar ways of behaving which takes these relations and power differences for granted. Ideologies are closely linked to language, because using language is the most commonest form of social behaviour, and the form of social behaviour where we rely most on 'commonsense' assumptions. (Fairclough, 2001, p.2)

Language is just another factor to consider when discussing social stratification and access to power among historically oppressed and highly marginalized populations.

Fairclough (2001) indicated that a society reinforces assumptions through implicit everyday social interactions, which are ideologies. The power elite utilize language to reinforce ideological beliefs and values, which reinforce existing social structures in maintaining the status quo.

Queer theory looks at the utilization of language and how it is conceptualized by the power elite to distinguish between the normal (e.g., heterosexuality) and the abnormal (e.g., homosexuality) within a dominant oppressive social structure. Fairclough (2001, p.16) states that: "…social conditions determine properties of discourse." Hence, the power elite's dominant role in society dictates what is normal, but queer theory reverses the discourse and demonstrates the limitations of conceptualizing normal from abnormal. Queer theory emphasizes four main ideological concepts (i.e., biological sex, gender, sexual identity, sexual behavior) that are reinforced by the power elite and contextualizes the concepts based on culture, time, and space.

Queer theory states that sexual identities such as heterosexuality and homosexuality are social constructs created by the power elite to reinforce patriarchic structures and subjugate a sexual minority through gender roles (Jagose, 1996; Watson, 2005). Heterosexuality did not become a prevalent identity until homosexuality was identified as a "problem" in society. The power elite regard heterosexuality as the ideal natural because it allows people to procreate (Jagose, 1996). Homosexuality is considered an abnormality because it does not lead to procreation and is a derivative of heterosexuality (Jagose, 1996).

Sexual orientation and gender are social constructs that are culture-dependent, relational and nonobjective (Jagose, 1996). The power elite argue that gender provides a

natural script for males and females to follow which reinforces heterosexuality as a natural social construct. Queer theory states that sexual orientation and gender are both fluid and dependent on time and space, and therefore, contradicts the argument that heterosexuality is a natural state and homosexuality an abnormal state. The power elite decree that heterosexuality is a stable trait in order to reinforce a patriarchal structure and maintain their domination over society.

A newly established queer identity and community fostered an opportunity for queers to set the foundation for queer theory, which analyzes how dominant ideologies centralize power and oppress homosexuals through patriarchic structures. Queer theory was affected by theoretical paradigms such as post-structuralism, theories of discourse, feminism, and the ethnic model (Jagose, 1996; Watson, 2005). Foucault strongly influenced the concept of identity being dependent on time and culture (Jagose, 1996; Watson, 2005). Homosexuality has existed throughout cultures and has been perceived positively and negatively throughout time. Once the potential power disruption created by an increasingly vocal homosexual community became evident, the power elite reacted by emphasizing that heterosexuality was the "normal" role for society to embrace. Current emphasis on heterosexuality and homosexuality places a focus on sexual identity, which is still developing into a coherent model (Jagose, 1996).

Social stratification depends on various factors (e.g., biological sex, gender, sexual identity, sexual behavior) to reinforce social norms and subjugate social deviants. Biological sex for example is a medical diagnosis determined at birth based on genitalia. An infant born with male genitals is assigned the biological sex of male and an infant born with female genitals is assigned the biological sex of female, but sometimes an

infant is born with ambiguous genitalia, a condition referred to as intersex. Intersex infants undergo further physical exams and blood tests to analyze their chromosomes and hormone levels (Merck, 2006), which depend on the test results to assign their biological sex at birth.

Gender is a social construct that is determined by the power elite that places an emphasis on socially desirable traits (i.e., behavioral, social, cultural) assigned to males and females, which is dependent on culture and time. Socially desirable traits for American males (i.e., masculinity) for example, require them to be dominant, independent, strong, and aggressive. Socially desirable traits for American females (i.e., femininity) are passivity, dependency, weakness, and submissiveness.

Queer theory argues that a gender is fluid and dependent on time, space, and culture. A "masculine" male might be dominant in the workplace, but submissive with a police officer. A "feminine" female might be submissive to her partner, but aggressive in the workplace. The power elite reinforce social scripts to maintain order in society, which could at times conflict with desirable gender traits assigned to a biological sex. A female's role as an officer places her in a role of power and authority, which requires "masculine" males to obey her role as an authority figure. The example of the female officer creates a conundrum for social scripts assigned to biological sex, gender, and authority.

Sexual behavior and identity (e.g., heterosexual, bisexual, homosexual) are social constructs also determined by the power elite to reinforce power and status in society. Helminiak (2000) indicates that a distinction must be made between sexual behavior and sexual identity. Helminiak (2000) uses the term *homogenitality* to refer to the

act/behavior of having same sex acts and the term homosexuality refers to a particular way of being. The term MSM has been utilized in epidemiology to encompass sexual behavior regardless of sexual identity, but the problem is that sexual identity includes a culture or lifestyle as opposed to *homogenitality*, which solely focuses on the sexual act/behavior. MSM that identify as heterosexual or bisexual have a different lifestyle or way of being that may not be addressed through traditional HIV interventions that were originally designed for gay white men and "adapted" for Latino and black MSM. Sexual identity as a homosexual allows greater access to resources (e.g., HIV interventions, condoms, gay community support) to reduce exposure to HIV transmission, but heterosexual MSM are less likely to respond to HIV interventions for gay men.

The MSM categorization which is based on sexual behavior (i.e., *homogenitality*) regardless of sexual identity (i.e., homosexuality) has impeded efforts in addressing the HIV/AIDS epidemic among historically oppressed populations. An emphasis on historically oppressed populations tells a different story than that of a white MSM who has white privilege and access to resources. A report by the Prison Policy Initiative (Wagner, 2005) indicated that in 2004 incarcerations were 6.9 times greater for black males than white males and 2.4 times greater for Latino males. Oppression and inequality are critical factors to consider when discussing the HIV/AIDS epidemic among Latino and black males. Incarceration is just one factor to consider regarding how the power elite reinforce inequality through social structures, as well as the implications for HIV prevalence rates among historically oppressed populations. Further questions are posed for consideration in utilizing MSM as a category in HIV prevention: How many homosexual encounters does it take to be categorized as an MSM? Does a homosexual

encounter need to occur every 3 months, 6 months, or 12 months to be considered an MSM? Do periodic episodes of homosexual encounters designate someone as an MSM? Does a victim of homosexual rape or abuse designate someone as an MSM? Overall, MSM is an epidemiological term to categorize men who have sex with men and does not take into account factors related to identity and/or culture.

Jagose (1996) indicated that it is important to distinguish between homosexual behavior and identity in order to understand oppression based on sexuality. Sexual identity is limited by its definition, because sexual identity is constantly shifting due to its dependence on time and culture (Watson, 2005). "Metrosexual" was a term introduced in the 21st century to personify a heterosexual man that takes extra effort in maintaining his appearance through various activities that were once considered highly effeminate such as eyebrow plucking, waxing, manicures, and pedicures. A *pretty boy* is no longer stigmatized as being gay, but personified as a male that takes pride in his appearance. Certain behaviors are stigmatized as gay in one culture and heterosexual in another culture. American men who are holding hands are stigmatized as gay, but it is common to see heterosexual men in India holding hands without being stigmatized as gay.

Queer theory emphasizes that one can question such structures and reverse the discourse (Valocchi, 2005; Watson, 2005). A person is an actor in society who chooses to reinforce or challenge the script that the power elite imposes, which in this case would be a heterosexual masculine role for males (Valocchi, 2005). Therefore, when a male actor is exposed to gender conformity within his social network he is able to confront or reinforce oppressive gender structures. The power elite define homosexuality as an abnormal deviation from heterosexuality to reinforce a patriarchic power structure.

Homosexual oppression is conceptualized through the constraints of sex and gender (Jagose, 1996). The power elite reinforce a patriarchic structure through social scripts for "men" to get married, have children, and become the head of the household. A "true" man does not partake in homosexual behavior and allow his manhood to be taken away by another male penetrating him. Sex and gender do not remain in a constant state, and a social construct (i.e., gender) does not define biological assignment (i.e., sex). Queer theory encompasses various factors that comprise race, gender, and sexuality and emphasizes the fluidity of the factors in creating an identity (Watson, 2005). The power elite argue that gender and sexuality are independent factors that are uniquely defined, but queer theory emphasizes that gender and sexuality are influenced by culture and other factors throughout one's development (Valocchi, 2005). Gender and sexuality are not static, but are dependent on time and social space. For example, one is not extremely masculine consistently throughout time and levels of masculinity or femininity might vary. Identities are fluid and adapt to cultural expectations and norms (Valocchi, 2005).

Cultural expectations and norms impose additional layers in conceptualizing gender and sexuality. The gay community applied the ethnic model to homosexual oppression to show how homosexuals are a distinct and identifiable population based on similar beliefs and values (Jagose, 1996). The ethnic model provided the queer community with a framework to demonstrate to society that they are a designated minority group being oppressed based on their sexuality. Feminists and people of color criticized the queer community on race and sexual identity and expressed concerns that issues predominantly addressed the concerns of gay white men (Jagose, 1996).

Queer identity provides a re-conceptualization of personal identification and political organization (Jagose, 1996). Lesbians and people of color felt that their concerns were not being addressed in the queer movement. As homosexuality evolved as an identity and social culture, people within the homosexual community continued to be historically oppressed based on biological sex (i.e., females) and/or race (e.g., Latinos, African Americans, Asians). Queer theory provided an opportunity for feminists and people of color to share their lived experiences and enhance the theoretical approach in addressing oppressive structures.

Homosexuals struggling with multiple stigmas based on sexuality, race, and biological sex emphasized factors such as power, entitlement, and privilege and the influence they had on reinforcing inequality. Oppression based on race, biological sex, and sexuality gives greater insight into how the power elite reinforce social stratification. It also shows that the implications for power and status are based on white privilege despite their sexual minority status. Feminists and people of color emphasize how the queer community reinforces the status quo of the power elite through a dominant white male queer culture, which perpetuates the dysfunctional cycle of social stratification within an oppressed queer community. The dysfunctional cycle of oppression is perpetuated by gatekeepers (i.e., gay white men) determining what issues to address with the power elite. Power and status is determined in the queer community through social scripts that have been designated by the power elite on race (i.e., white), biological sex (i.e., men), and gender (i.e., masculine men, feminine women).

Queer theory looks at social constraints and how inequality is reinforced by the power elite based on race, gender, and sexuality. Social policy emphasizes that

heterosexuality is a natural concept and masculinity is an essential aspect of a productive male in society. The power elite states that sexuality and gender are stable definitions designated to emphasize appropriate roles in society. Homosexuality is viewed as an abnormality that is a derivative of heterosexuality. Queer theory emphasizes that one critical problem with sexual identity is in the contradictions that arise when it is applied to homosexuality (Jagose, 1996). Queer theory introduces the concepts of transitivity among homosexuals within a social context. Transitivity occurs by stigmatizing HIV as a gay disease and restricts homosexuals (including lesbians) from donating blood, despite the fact that HIV prevalence rates among lesbians are low (Jagose, 1996). Transitivity looks at the stigmatization of homosexuals and targeting them as the cause of the AIDS crises, which includes lesbian women as well without any plausible reasoning. Low HIV prevalence rates have been reported due to women having sex with women, but females that tested positive and had sex with another female have reported HIV infection due to high risk behaviors such as IDU, CSW, and/or sex with "high risk" males (CDC, 2006).

Summary

The power elite focus on the people (e.g., Latinos, blacks, MSM) affected by the social problem (e.g., HIV/AIDS) and blame them for causing the problem, as opposed to looking at the role the power elite and social structures play in reinforcing inequality, which causes inequality to be the catalyst of the social problem. The economic recession for example has caused the government (e.g., CDC) to emphasize that they are providing society with the tools (e.g., Diffusion of Effective Behavioral Interventions) for addressing the HIV/AIDS epidemic and requires greater accountability by the communities to ensure their own well-being. The issue is not about exceedingly greater

profits being made by the power elite (e.g., pharmaceutical companies, politicians) and/or extended ADAP waiting lists for PLWHA, but a matter of communities (e.g., Latinos, blacks, MSM) not becoming dependent on the government.

Jagose (1996) emphasizes that separation occurs in the general population based on sexual behavior, separating sexual identity (i.e., homosexuality) from sexual behavior (i.e., *homogenitality*). For example, HIV interventions were ineffective when they targeted MSM as a population because they are not part of a community such as self-identified homosexuals (Jagose, 1996) and a portion of MSM (e.g., straight, bisexual) do not identify with the gay community. The categorization of MSM as a unique population for HIV interventions failed because MSM do not have a shared culture of beliefs and were grouped based on their sexual behavior (i.e., *homogenitality*). Yet these interventions continue to be supported by the CDC as "one size fits all" and used in gay communities of color. Queer theory criticizes how society addresses social problems through social constructs and reemphasizes the incoherent utilization of the concepts related to sexuality.

Queer theory has a radical ideological approach towards opposing homosexuality as a social problem. Many of the principles of queer theory focus on how society reinforces patriarchic values and oppresses homosexuals based on gender and sexuality. Queer theory also looks at how patriarchy, racism, and heterosexism influence one another in reinforcing oppression. Social stratification demonstrates how several factors such as race, sex, gender, and sexuality influence inequality and the interests of the power elite. Oppression is a result of capitalism that excludes a group based on characteristics that deviate from the dominant group's norms and values. Queer theory rejects the

argument that emphasizes heterosexuality as a normal state and homosexuality as an abnormal state. Queer theory argues that homosexuality is just as normal as heterosexuality based on the same premise of sexual and gender constructs. Sexual behavior has existed throughout time and heterosexual behavior was in concordance with homosexual behavior. Heterosexuality was not the true normal role because homosexuality existed. Gender also follows the same trajectory as sexuality, but gender emphasizes the significance of time and space. Gender is not a set role, but is continuously transformed throughout time and space. Queer theory emphasizes that gender and sexuality cannot be categorized in terms of origin. Queer identity is viewed as a constant development of self, it is never complete. Therefore, queer theory emphasizes that oppression of homosexuals is based on patriarchic structures because sexuality and gender are not stable throughout one's life. Sexuality and gender are social constructs that are continuously in the process of development. Stigmatization of homosexuality is based on reinforcing the power structures for heterosexual white males.

Overall, the application of power elite theory and queer theory in this study enhances the conceptualization of how power and status influence knowledge and attitudes towards HIV/AIDS. Most importantly, this research study explored the implications of the HIV/AIDS epidemic at the level of social structures as opposed to existing research initiatives which have focused on individual and group interventions.

4. Faith-based Initiatives: Power, Ideology, & Dissemination of Resources

Although religious institutions have historically taken an active role in addressing the needs of underserved populations, the U.S. government has maintained a separation between church and state. President George W. Bush made history in January 2001 when he launched the Faith-based and Community Initiative (FBCI), which allocated government funds for Faith-Based Organizations (FBO) (White House, 2008). The FBCI reinforced conservative views of less government involvement and greater community initiatives for addressing the needs of underserved communities. The government restructured policies and dissemination of grants to ensure "equal treatment" for FBOs, which resulted in the establishment of FBCI centers[4] within federal agencies to strengthen opportunities for FBOs (White House, 2008). Implementation of the FBCI required President Bush to issue Executive Order 13279 in 2002 which ensured that:

- Faith-based organizations are eligible to participate in Federal social service programs on the same basis as any other nonprofit organization, and agencies that distribute Federal funds cannot discriminate either for or against an organization on the basis of religion or religious belief.
- Faith-based grantees cannot use "direct" Federal funds to support "inherently religious activities" (e.g., worship, proselytizing). Inherently religious activities must be voluntary for program or service beneficiaries.
- Faith-based grantees may integrate inherently religious activities into their programs or services that receive Federal funds indirectly from individuals who exercised their free choice to select such grantees (e.g., vouchers).
- Faith-based grantees retain their independence from government and are not required to forfeit or change their religious name, mission, or governance.

[4] Federal Centers for Faith-based and Community Initiatives: Center at the U.S. Department of Health and Human Services (HHS), Center at the U.S. Department of Commerce, Center at the U.S. Department of Housing and Urban Development (HUD), Center at the U.S. Department of Veterans Affairs (VA), Center at the U.S. Department of Agriculture, Center at the U.S. Department of Homeland Security (DHS), Center at the U.S. Agency for International Development (USAID), Center at the U.S. Department of Education, Center at the Small Business Administration, Center at the U.S. Department of Labor, Center at the U.S. Department of Justice, and Corporation for National and Community Service.

- Every grantee, including faith-based organizations, must serve any client who qualifies for services, regardless of his or her religious belief or lack thereof. White House (2008, pp.30-31)

The FBCI required a significant investment in training government personnel as well as faith-based community organizations. "Overall, the Office of Faith-based and Community Initiatives (OFBCI) and Federal agencies have provided in-person training to more than 150,000 social entrepreneurs, building skills that help organizations maximize their resources and capacity to serve" (White House, 2008, p. 36).

While the FBCI seems harmless with its goal to address the needs of underserved populations, what happens when religious ideology conflicts with the needs of historically oppressed and highly marginalized populations? This chapter will apply power elite and queer theory as the analytical lens to study how social structures (e.g., religious institutions, FBOs) reinforce ideology (i.e., religious rhetoric) and the potential implications on social services for vulnerable populations. For instance, FBOs have a significant amount of control over underserved populations since the FBOs decide who receives the resources they control.

An emphasis will be placed on ideology and how it reinforces social stratification through religious beliefs and values in the community, which makes the distinction between "acceptable" and "deviant" behavior in the community. One section will explore the historical influence religious fundamentalism has had in the U.S. and the influence missionaries have in low and middle income states (e.g., Guatemala). The end of the chapter will discuss the implications of FBCI focusing on the impact it has on responses to the HIV/AIDS pandemic.

4.1. *Religious Ideology*

> We are not really worried about queers here or homosexuality per se. Instead, we are worried about the power and control and who will assure that sovereignty, rule, power, and tradition reign in anything that tries to break the foundation, the law, upon which all God's will rules – the traditional family. (Cobb, 2006, p.29)

The chapter on theory looks at how the shift of power allows the power elite to determine dissemination of a society's resources. Queer theory highlights how the power elite utilize language to conceptualize social problems and oppress minorities. People, regardless of their levels of religiosity, have referenced the Bible to condemn homosexuality. God, epitomized as the source of unquestioned authority, dictates right and wrong. The Bible is perceived as the absolute source of God's word and cannot be challenged (Cobb, 2006). Theologians and religious leaders (i.e., the power elite) shape the ideologies of their religious communities and interpret religious texts to guide religious followers away from condemnation.

Critics point out that the Bible is an ancient text which has gone through numerous translations and interpretations, which becomes an "entitled" language that requires special skills to determine its meaning (Cobb, 2006). Helminiak (2000) emphasizes the need for contextualizing the Bible and distinguishing a literal reading from a historical-critical reading. A literal reading looks at the text as it is written without interpretation or consideration of the historical context (Helminiak, 2000). Historical-critical reading requires one to consider what the text meant at the time it was written and adapts those lessons to the present (Helminiak, 2000). "Historical-critical study of the Bible oftentimes reverses some long-standing interpretations and raises very serious questions about religion and society" (Helminiak, 2000, pp. 33-34). Regardless

of how the Bible is interpreted (literal or historical-critical) many Christians perceived it as inerrant (Cobb, 2006; Helminiak, 2000). This chapter applies a historical-critical reading of the Bible to demonstrate how the power elite utilize religious rhetoric to serve or interpret current events.

An emphasis will be placed on passages in the Bible that have been used to condemn homosexuality. Helminiak (2000) makes the distinction between homosexuality and *homogenitality* to place the biblical text into the context of time and space. Homosexuality as a culture and social problem is a modern development.

> Specifically, in biblical times there was no elaborated understanding of *homosexuality* as a sexual orientation. The ancient Israelites did not even think about sex in these terms. There was only a general awareness of same-sex contacts or same-sex acts, what can be called *homogenitality* and *homogenital* acts. (Helminiak, 2000, p.39)

Helminiak (2000, pp.43-44) indicates that there are five biblical passages which religious communities use to condemn homosexuality: 1) Sodom & Gomorrah; 2) Leviticus 18:22 & 20:13; 3) Saint Paul's Letter to the Romans 1:27; 4) 1 Corinthians 6:9; and 5) Timothy 1:10. The following section will review the five biblical passages and the implications religious ideology has on reinforcing homophobia as a modern social problem.

4.1.1. *Sodom & Gomorrah*

The story of Sodom and Gomorrah has been used since the 12th century to condemn homosexuality (Helminiak, 2000). The word "sodomite" is derived from the story of Sodom and Gomorrah, which refers to someone who engages in anal sex and in the case of Sodom, homogenital behavior (Helminiak, 2000). The following is the story of Sodom and Gomorrah:

> The two angels came to Sodom in the evening; and Lot was sitting in the gateway of Sodom. When Lot saw them, he rose to meet them, and bowed down with his face to the ground. He said, "Please, my lords, turn aside to your servant's house and spend the night, and wash your feet; then you can rise early and go on your way." They said, "No; we will spend the night in the square." But he urged them strongly; so they turned aside to him and entered his house; and he made them a feast, and baked unleavened bread, and they ate. But before they lay down, the men of the city, the men of Sodom, both young and old, all the people to the last man, surrounded the house; and they called to Lot, "Where are the men who came to you tonight? Bring them out to us, so that we may know them." Lot went out of the door to the men, shut the door after him, and said, "I beg you, my brothers, do not act so wickedly. Look, I have two daughters who have not known a man; let me bring them to you, and do to them as you please; only do nothing to these men, for they have come under the shelter of my roof." But they replied, "Stand back!" And they said, "This fellow came here as an alien [Lot was not originally from Sodom], and he would play the judge! Now we will deal worse with you than with them." Then they pressed hard against the man Lot, and came near the door to break it down. But the men inside reached out their hands and brought Lot into the house with them, and shut the door. And they struck with blindness the men who were at the door of the house, both small and great, so that they were unable to find the door.
> (Genesis Chapter 19 verses 1-11, as cited in Helminiak, 2000, pp.43-44)

People have used this story to illustrate God's condemnation of homosexuality and the citizens of Sodom by engulfing the village in flames (Helminiak, 2000). Recent findings have developed new theories regarding the destruction of Sodom and Gomorrah. Scholars (e.g., geologists, climatologists, archeologists) have indicated that some stories in the Bible are explanations of natural events (Evans, 2008). They point to the possibility of an asteroid colliding with the earth with plumes from the eruption showering cities around the Dead Sea, including Sodom and Gomorrah (Evans, 2008). The plumes included flames that were over 500 degrees Fahrenheit which would have burned everything they touched. The story of Sodom and Gomorrah uses a natural disaster (i.e., asteroid colliding with the earth) to reinforce ideology and promote obedience among religious followers, in this case, discouraging males from engaging in

homogenital acts. People who deviated from the accepted religious beliefs (i.e., heterosexuality) would be punished by God.

Helminiak (2000) further indicates that the Hebrew term “to know” in the Bible usually refers to having intercourse, a point agreed on by most Biblical scholars. This would indicate that the male citizens of Sodom did indeed want to have intercourse with the male visitors. However, some scholars argue that in this passage the term “to know” meant that the men of Sodom wanted to make friends with the two visitors (Helminiak, 2000). Helminiak (2000) points out that Lot’s offering of his two daughters implies the sexual reference for “to know” the two visitors. The critical emphasis is that the men of Sodom imposed themselves on the two visitors, which implies rape and not consensual sex between two males (Helminiak, 2000). Male on male rape was seen as a subjugation of the enemy and/or threat and demonstrated one’s dominion over the other. Helminiak (2000) indicates that historically during war the male victors would rape the defeated soldiers as a form of demasculinization to impose the greatest insult, which was to take the role of a female.

The offense was not consensual male to male sex, but the abuse of power and rape of the two visitors (Helminiak, 2000). The people of Sodom were always skeptical of strangers/foreigners (Helminiak, 2000). The moral of the story was for one to be hospitable towards visitors and welcome them into foreign surroundings. One should not abuse one’s power and use it for personal gratification. The story of Sodom also implies that one should not abuse one’s power over vulnerable slaves and coerce them into having sex. The story refers to that society’s constraints on rape rather than on consensual sex between men. The story also speaks to the social norm of sharing your

wealth with the less fortunate and extending hospitality to a guest/visitor. Mexican culture reinforces generosity towards guests despite of one's financial means. The host always ensures that the guest is well fed and feels comfortable in a foreign home even if it results in the host making sacrifices (e.g., not eating, sleeping on the couch), which is contextualizing the historical-critical reading of the Bible into the present. Helminiak (2000) states:

> There is a sad irony about the story of Sodom when understood in its own historical setting. People oppose and abuse homosexual men and women for being different, odd, strange, or as they say, "queer." Lesbian women and gay men are just not allowed to fit in. They are made to be outsiders, foreigners in our society. They are disowned by their families, separated from their children, fired from their jobs, evicted from their apartments and neighborhoods, insulted by public figures, denounced from the pulpit, vilified on religious radio and TV, and then beaten in the schools and killed on the streets and in the backwoods of our nation. All this is done in the name of religion and Judeo-Christian morality. (p.49)

The story of Sodom and Gomorrah might not be clear on homosexuality, but Leviticus clearly states that homosexuality between males is an abomination. The following section reviews the biblical passage and its implications for homosexuality in present society.

4.1.2. ***Leviticus 18:22 & 20:13***

> Leviticus 18:22 states, "You shall not lie with a male as with a woman; it is an abomination." Then Leviticus 20:13, completing this reference, adds the punishment: "If a man lies with a male as with a woman, both of them have committed an abomination; they shall be put to death, their blood is upon them." (Helminiak 2000, p.51)

This passage is clear in its implications for *homogenitality* between males, but Helminiak (2000) cautions the reader to contextualize the text and take into account the historical-critical reading in relation to time and space. Death was a common penalty at the time and not limited to *homogenitality* between males and acts such as adultery, incest, and

bestiality were also punishable by death (Helminiak, 2000). The patriarchy of the family structure in society played a significant role at the time, which maintained order and obedience in society (Helminiak, 2000). The eldest male in the family was at the pinnacle of the hierarchy and inheritance of property was only bestowed to males (Helminiak, 2000). Therefore, the existence of one's lineage and status in society depended on male heirs, which placed an emphasis on procreation.

The Israelites prominence in the territory relied on the patriarchy structure of male dominance and entitlement. The Israelites regarded themselves above other nations and they maintained a sense of entitlement that enforced "The Holiness Code," a set of laws that maintained their status as the chosen people (Helminiak, 2000). Helminiak (2000) states:

> According to Jewish belief, Israel was God's "chosen people." Israel was bound to God by a covenant, a pact. The covenant required the Israelites show themselves different from the other nations. They were God's people. They were to maintain their own traditions. They were not to do things the way other nations did. They needed to preserve their religious identity. "With God's help" they had conquered the Canaanites and had taken over the Canaanite territory as their own "promised land." They now were to have nothing to do with Gentiles. To remain separate from the Gentiles was to be "holy" – set apart, different, chosen, special, consecrated. They were to be like God, who is awesome, different, set apart. Differentness or specialness is the core meaning of holiness in the ancient Hebrew understanding. (pp.53-54)

The Canaanites, unlike the Israelites, had religious rituals where the entire extended family had sex with one another, which included *homogenitality* between father and son (Helminiak, 2000). Helminiak (2000) indicates that the Israelites refrained from homogenital acts because of their unique status as the "chosen people," which separated them from the Gentiles. "Homogenital sex is forbidden because it is associated with Gentile identity" (Helminiak, p.54). The Israelites needed to set themselves apart from

others and maintain their own religious identity. Hence, Helminiak (2000) indicates that restrictions to partake in *homogenitality* were based on religious beliefs and not as a moral or ethical issue.

Present day Christians that would quote Biblical texts condemning *homogenitality* should not isolate their reading to specific passages. The death penalty was also used for adultery, but few would condone its use today even though they condemn divorce and uphold the sanctity of marriage.

The Israelites belief that they were the chosen people meant that they had to set themselves apart from other nations, which required them to maintain unique religious practices. "Leviticus was concerned about social and religious taboos; we are concerned about sexual ethics" (Helminiak 2000, p.66). As the chapter on the history of homosexuality indicates, homosexuality is a modern social problem that threatens the power elites' beliefs and values on establishing an acceptable society. Presently, there are religious enclaves that reinforce religious beliefs and values, but they establish their own fundamental communities to protect their people from the outside world. Religious fundamentalism and its implications for historically oppressed and highly marginalized populations will be discussed later in this chapter, but it is essential to understand the utilization of religious text to stigmatize homosexuality.

4.1.3. *Saint Paul's Letter to the Romans*

> [18]For the wrath of God is revealed from heaven against all ungodliness (***asebeia***) and wickedness (***adikia***) of those who by their wickedness suppress the truth. [19]For what can be known by God is plain to them, because God has shown it to them. [20]Ever since the creation of the world his eternal power and divine nature, invisible though they are, have been understood and seen through the things he has made. So they are without excuse; [21]for though they knew God, they did not honor him as God or give thanks to him, but they became futile in their thinking and their senseless minds were darkened. [22]Claiming to be wise, they became fools; [23]and they exchanged the glory of the immortal God for images resembling a mortal human being or birds or four-footed animals or reptiles.
>
> [24]Therefore God gave them up in lusts of their heart to impurity (***akatharsia***), to the degrading (***atimazesthai***) of their bodies among themselves, [25]because they exchanged the truth about God for a lie and worshipped and served the creature rather than the Creator, who is blessed forever! Amen.
>
> [26]For this reason God gave them up to degrading (***atimias***) passions. Their women exchanged natural (***physiken***) intercourse for unnatural (***para physin***), [27]and in the same way also the men, giving up natural (***physiken***) intercourse with women, were consumed with passion for one another. Men committed shameless (***aschemosyne***) acts with men and received in their own persons the due penalty for their error.
>
> [28]And since they did not see fit to acknowledge God, God gave them up to a base mind and to things that should not be done. [29]They were filled (***pepleromenous***) with every kind of wickedness (***adickia***), evil, covetousness, malice. Full of envy, murder strife, deceit, craftiness, they are gossips, [30]slanderers, God-haters, insolent haughty, boastful, inventors of evil, rebellious towards parents, [31]foolish, faithless, heartless, ruthless. [32]They know God's decree, that those who do such things deserve to die – yet they not only do them but even applaud those who practice them.
> (Romans 1:18-32, as cited in Helminiak 2000, pp. 76-77)

Paul's letter to the Romans is addressed to the Jewish community as well as Gentiles, who were at conflict at the time. Paul refers to Jewish self-righteousness to gain the attention of an audience that saw themselves as superior to Gentiles (Helminiak, 2000). Paul's intent was to show that salvation comes to everyone who has faith in God,

including Gentiles. A disregard for God was the sin that resulted in impure acts (e.g., adultery, incest, *homogenitality*) leading to impurity. The literature indicates that true sin is not worshiping God and an act of impurity does not result in real sin.

Cleanliness distinguished the chosen people from Gentiles. Circumcision for example was only practiced in the Jewish community. Circumcision is currently common among males outside of the Jewish population, but the debate of circumcision still continues, however uncircumcised males are not seen as sinful and/or condemned to hell.

Helminiak (2000) indicates that people refer to Paul's Letter to the Romans as a source that indicates homosexuality is unnatural and that diseases (e.g., HIV/AIDS) are seen as a punishment for *homogenitality*. The argument that sexually transmitted infections are a consequence for sinful behavior does not hold much substance because they are also experienced by heterosexuals (Helminiak, 2000). This passage refers to lesbian (verse 26) as well as homosexual (verse 27) sex, but Helminiak (2000) uses the original Greek words (in parentheses and bolded) to discuss the implications of translation and meaning in the present. The Greek words could be translated as is in the passage, but they can have other meanings. Heminiak (2000) gives some insight into the issues encountered with interpreting religious biblical text:

- ***asebeia*** means that it is wrong in general; Paul utilizes the term as being free of ethical condemnation.
- ***adikia*** is referred to as *wickedness,* the word is similar to *asebeia* and it means that it is wrong in general; Paul utilizes the term as being free of ethical condemnation.
- ***akatharsia*** is referred to as *impurity* – "Paul wants to teach an important Christian lesson on morality. He wants to emphasize the difference between ritual impurity and real wrong" (Helminiak, 2000, p.94).

Paul's letter is for Gentiles as well as Jews and he is emphasizing how one must resist temptation to sin. "He wants all to know the salvation that comes to everyone who has faith…" (Helminiak, 2000, p. 102). Paul further stated that "nothing is unclean," which also included food (Helminiak, 2000). Helminiak (2000) indicates that the focus on *homogenitality* was based on the implications of his target audience, which included Jews and Gentiles. Homosexuality was not controversial for his target audience unlike circumcision or food, which were very controversial topics at the time and space in which the letter was written. Overall, an emphasis is placed on religious practice, not ethical condemnation as Moen (2009) further clarifies the origin of *akatharsia* and its implications:

> This word comes from ***kathairo*** (we derive the English "catharsis"). Here Paul makes it a negative, so the meaning is "not cleansed". The background of ***katharos*** is ritual cleansing. It is not the same word that is used for the purity of holiness before God. That word is ***hagnos*** (it comes from a word meaning "to stand in awe").
>
> The Bible says over and over that no amount of ritual conformity on our part will ever make us holy and acceptable to God. Only God can clean us up from the inside. God will do the real cleansing. He will wash away all the guilt and all the judgment. He will forgive.

- ***atimazesthai*** is referred to as *degrading*, but an emphasis is placed again on the intent of the letter to a target audience that included Gentiles. Paul is not imposing ethical condemnation of homosexuality, Corvino (1997, pp. 90-91) further states:

  > Paul began his letter by seeking the goodwill of the Jewish converts. In fact, seeming to side with their prejudice, he was saying with them, "The Gentiles are a dirty lot!" For this ploy to work, Paul had to be circumspect at first about his position. He phrased it in terms that would let the Jewish Christians think they heard what they wanted to hear...But what his audience heard might be another matter. Paul's rhetorical strategy required some degree of ambiguity.

- ***atimias*** is *translated* as *degrading*, but it can also mean not highly valued and/or regarded; which is free of ethical judgment.
- ***physiken*** is *translated* as *natural*, but it is referring to what is the social norm and not "in accord with universal laws."
- ***para physin*** is *translated* as *unnatural*, it can also mean to support or supplement. Based on Paul's usage it is referring to the unexpectedness/unusualness of an act, not necessarily "contrary to nature." A more appropriate translation would be "atypical."
- ***aschemosyne*** is *translated* as *shameless*, but it is referring to inappropriate/unseemly.
- ***pepleromenous*** is *translated* as already filled, Helminiak (2000, p.96) further states: "The point is that impurity should not be run together with the wickedness, for the time of the wickedness and the time of the impurity are not the same. The wickedness was part of the picture before the impurities."

Paul's overall intent is to show that idolatry leads to impurity (Helminiak, 2000). The actual sin is to not worship God, which leads one towards the wrong path and more susceptible to partake in wrongful acts.

Homogenitality was used to demonstrate the implications for turning ones back on God, but salvation comes to **anyone** that has faith in God. Paul's letter to the Romans can be misleading as Helminiak (2000) indicates. One must consider the context of the target audience and accurate translations of the text, which are determined by time and space. Therefore, Paul's letter to the Romans places no ethical condemnation of homosexuality.

4.1.4. *1 Corinthians 6:9 & 1 Timothy 1:9*

Helminiak (2000) indicates that the meaning of 1 Corinthians 6:9-10 and 1 Timothy 1:9-10 are dependent on the meaning of two Greek words (i.e., malakoi, arsenkoitai), which has multiple translations. Helminiak (2000) states:

> The bottom line on this discussion is as follows: ***Malakoi*** has no specific reference to homogenitality. On the other hand, ***arsenkoitai***, which occurs in two texts, ***may*** be some kind of reference to male same sex acts. If it is, these texts condemn wanton, lewd irresponsible male homogenital acts but not homogenital acts in general. (p.105)

Helminiak (2000) further indicates that both Greek words are difficult to interpret due to the lack of context when used in the text, but it is apparent that the words refer to something evil. The following passage is a revised version of 1952 for 1 Corinthians 6:9-10 (as cited in Helminiak, 2000, p.106): "Do not be deceived neither the immoral, nor idolators, nor adulterers, nor homosexuals **(oute malakoi oute arsenkoitai)**, nor thieves, nor the greedy, nor drunkards, nor revilers, nor robbers will inherit the kingdom of God." Helminiak (2000) also cites the following 1989 translation for 1 Timothy 1:9-10:

> the law is laid down not for the innocent but for the lawless and disobedient, for the godless and sinners, for the unholy and profane, for those who kill their father or mother, for murderers, fornicators, sodomites (***arsenkoitai***),slave traders, liars, perjurers and whatever else is contrary to the sound teaching… (p.106)

Overall, there has been no consensus on an accurate translation of the religious text and it varies by person, time, and space. Helminiak (2000) emphasizes that the translation of the biblical passage refers to prejudices at the time for ***Malakoi*** (e.g., catamites, sissies, effeminate, boy prostitutes) and ***arsenkoitai*** (e.g., homosexuals, sodomites, child molesters, perverts).

As discussed in the theoretical section, power and status designate gate keepers who determine how to best address a social problem (e.g., HIV/AIDS) and disseminate resources within the community. Therefore, how do conservative religious leaders address the needs of a highly marginalized population (e.g., homosexuals, PLWHA) if it conflicts with their religious beliefs that homosexuality is a condemnation and HIV/AIDS

is punishment by God for immoral behavior? The following section will review the implications of policies and FBOs addressing HIV/AIDS among historically oppressed and highly marginalized populations. An emphasis will be placed on the characteristics of religious fundamentalism to demonstrate the influence that faith-based initiatives have on addressing the needs of historically oppressed and highly marginalized populations.

4.2. *Religious Fundamentalism*

Fundamentalists are a unique segment within the religious community. The history of fundamentalism in the U.S. demonstrates how a religious group organized to establish a social structure that reinforced their religious ideology through the government, education, and dissemination of resources. Once American Fundamentalists became established, missionaries were sent to low- and middle-income states to spread the gospel and save souls. The goal of religious fundamentalism is to become the dominant voice of the political, social, and cultural life of the state.

The term fundamentalism was first applied to the American Protestant movement in response to modernity's threat to religious beliefs and values in the late 19th century (Eskridge, 1995). Protestantism was the dominant religion in the U.S., but factors such as urbanization, industrialization, and immigration threatened the dominant American culture and religious foundation (Eskridge, 1995). Protestants began to feel like strangers in their own land and the modernization of society (i.e., urbanization, industrialization, immigration) threatened the religious foundation established in the U.S. "Arising in the United States around the turn of this century [20th], it [Protestants] set out a defense of orthodox beliefs about the Bible, a defense of traditional virtues and way of life" (Ammerman, 1994, pp.13-14). Fundamentalists took a stand in the 1920s to protect the

state's religious foundation. "They [Protestants] organized campaigns against religious liberalism in the churches and the teaching of evolution in the schools" (Ammerman, 1994, p.14).

Fundamentalists' crusade to save American culture was unsuccessful and modern ideals prospered. American culture steered away from Protestant values and society reinforced religion's antithesis to: diversity, individualism, autonomy, the search for knowledge, and capitalist society. "Modernity is seen as the great evil, born by the secular tradition and upheld by such 'foreign' values as democracy" (Lazarus-Yafeh, 1993, p.46). Extremely conservative Protestants (i.e., fundamentalists) reacted by establishing a foundation (e.g., social structure) based on their religious beliefs and values to protect future generations from evil temptation. Ammerman (1994) states:

> Despite their apparent defeat in these campaigns, fundamentalists proved resilient and innovative in the years ahead. They built an extensive institutional infrastructure, concentrating their energies on evangelism and missions, education and publishing. (p.14)

The Pentecostal movement had a following among poverty-stricken white and black communities in the South, but during the 1950s healing evangelists attracted more members from other U.S. communities (Eskridge, 1995). By the 1960s the Pentecostal movement began to influence other religious denominations such as the Roman Catholic and Orthodox churches (Eskridge, 1995). "The movement's visibility and networks were further strengthened by the success of the Pentecostal-leaning 'Jesus People' movement among American youth in the '60s and '70s" (Eskridge 1995, p.3). The fundamentalist movement was also gaining strength at this time (in numbers as well as resources such as educational institutions and literature). By the mid 1970s fundamentalists came back with a vengeance and they took an aggressive political role and mobilized their followers

to elect politicians that upheld their religious beliefs and values (Ammerman, 1994). The religious right had emerged and as Eskridge (1995) indicates:

> The reasons for this resurgence are many, including: a natural desire to have a positive impact on culture and society…; concern over abortion and changing sexual mores in society; and dissatisfaction with the content, direction and power of the mass media and popular culture. (p.5)

Fundamentalism is no longer limited to Pentecostals or Protestants in the U.S. and the revival has spread among other religions and overseas. Marty and Appleby (1994) indicate that fundamentalism is comprised of religious members that utilize various strategies in preserving religious beliefs and values. "In a word, *fundamentalism is orthodoxy in confrontation with modernity*" (Hunter, 1993, p.28). A religious group's response to modernity determines whether it is an orthodox or fundamentalist group. Orthodox groups reinforce their religious beliefs and values among members, with an emphasis on assimilating into society. Orthodox groups adapt to their environments and reside within larger society. As Sivan (1995, p.16) indicates, "The result is a state of limbo, the blurring of distinctions…" The orthodox are no longer orthodox, but adhere to an enmeshment of modernity and religious ideals. Fundamentalist groups also reinforce religious beliefs and values as orthodox groups, but fundamentalists confront modernity when it threatens their religious ideology. Fundamentalists place an emphasis on tradition and discourage members from deviating from the group. Heilman (1995) indicates:

> Conservative in outlook, fundamentalisms embrace tradition and appear to eschew even relatively limited changes in that tradition, even and perhaps especially when the tenor of the times seems to demand accommodations. They assert that they alone comprehend the meaning of history, understand the significance of the present moment, and see how past and future are connected. (p.173)

Fundamentalists establish communities that preserve their religious ideology with clear designated boundaries (i.e., enclaves) for members to distance themselves from outsiders. An enclave community protects its members from outside influences and creates a world that reinforces its religious beliefs and values. Fundamentalists insists that believers abide by religious laws, isolate themselves to the enclave, and resist influences from the outside culture (Lazarus-Yafeh, 1993). A protected and safe environment allows fundamentalists to raise their children without any influences from the outside, which prepares the next generation to continue the movement. Fundamentalists rely strongly on an established enclave of members identifying as "true believers" (Lazerus-Yafeh, 1993) that are exclusively selected to enforce an anti-secularist movement (Marty & Appleby, 1994). Fundamentalists require members of the enclave to identify as one, a community, towards the battle of the "holy cause" (Sivan, 1995). Members of the enclave are regarded as holy warriors' superior to outsiders because of their traditional morals and higher cause (Sivan, 1995). Fundamentalists create a community that provides a sense of direction and belonging in a chaotic and lonely world. Moral persuasion reinforces unity among fundamentalists to strengthen the wall of virtue and prevent members from leaving the group (Sivan, 1995). The enclave community supports its members and frowns upon members that deviate from the norm.

> Movements that fall within the family of comparative "fundamentalisms" have organized themselves for actions "over against" a dominant political, social, and/or religious culture; but many have also at some juncture adopted programs of withdrawal and isolation from society. (Marty & Appleby 1994, p.3)

Withdrawal and isolation from society can take the form of either quiescent or active fundamentalism. Fundamentalists that protect their group from outsiders,

discourage acculturation with mainstream society, and isolate themselves within their enclave are referred to as quiescent. Heilman (1995) describe quiescent fundamentalist as follows:

> The quiescent aspect of fundamentalism, simply stated, is an unyielding refusal to be moved from an attachment to a perceived tradition coupled with a structured resistance to contemporary culture and values, a resolute unwillingness to be absorbed by or to absorb them. (p.178)

Two essential elements, *traditionalism* and *contra-acculturation*, are required to determine if a group is fundamentalist (Heilman, 1995). *Traditionalism* states that following a religious lifestyle result in a better future. Fundamentalists tend to be dissatisfied with the state's failure to address disparities in their community. Their religious ideology provides direction on how to improve one's circumstances. Fundamentalists are pursuing their destiny and see the past as the ideal way of life. Preservation of their traditional values and resistance to modern ideals results in *contra-acculturation*. *Contra-acculturation* is where "…a particular way of life is sustained whose norms, values, patterns of behaviors, and even language are different from those in the larger host society" (Heilman 1995, p.176). Active fundamentalists also uphold *traditionalism* and *contra-acculturation*, but seek to expand their group into larger society. Their desire to expand leads to direct confrontation with the enemy/outsiders. As Heilman (1995) indicates:

> Yet there are important differences between the groups [quiescent and active fundamentalists]. While passivity encourages withdrawal, activity engenders expansion, which in turn necessarily involves the activist fundamentalist with the world beyond their borders. Thus the activists go out to meet the cultural enemy and often strike preemptively against it, drawing lines well beyond the boundaries their more passive counterparts have set. They push forward their own domains, going on the offensive to defend themselves and their way of life and faith. (p.184)

Fundamentalists believe that they are preparing for a battle between good and evil. The army of the fundamentalist is composed of missionaries that have gone through rigorous training for spreading the gospel and saving condemned souls. Evangelical members, as well as other religious groups, contribute financial resources to mobilize missionaries domestically as well as internationally to provide services for disenfranchised populations. An emphasis on the fundamentalist movement in Guatemala demonstrates the implications of providing resources through a faith-based initiative for underserved populations. The tangible outcomes (e.g., education, healthcare, housing) are indispensible, but one must also consider the significance of imposing religious rhetoric on a highly vulnerable population.

4.2.1. *Protestant Fundamentalism in Guatemala*

The fundamentalist movement in Guatemala seems to be headed down the same path as the American fundamentalist quiescent period prior to the mid-1970s. Catholicism was the dominant religious denomination in Guatemala, but its conservative religious views did not address the needs of the communities in Guatemala. Catholic priests go through a lengthy formal process of education and training before becoming responsible for a religious congregation. Evangelicals in Guatemala on the other hand provide opportunities for local members to become religious leaders and develop their own congregations to preach the gospel with minimal formal training. Native Evangelical leaders develop their following through one's lived experience and their established ties with the community allow them to integrate religious rhetoric with issues affecting the community.

Protestant missionaries in Guatemala succeeded in converting the largest number (1 in every 3) of Evangelicals in Latin America (Hockenberry, York, & Jersey, 1992). The missionaries realized that a large part of the Catholic community were passive members of the Catholic Church. They found religious rhetoric and authoritative methods of the priests irrelevant to their lives and obstacles they faced. Guatemalans were frustrated with the Catholic Church as well as their government for failing to address social disparities in their state. The Protestant missionaries capitalized on the frustrations encountered by Guatemalans and mobilized to provide services (e.g., medical, educational) that demonstrated the power of the gospel and served to build trusting relationships with the community.

The missionaries understood that they were guests in a foreign country and in order to save souls they needed to help Guatemalans become religious leaders and establish their own congregations. Unlike the process for becoming a Catholic priest, the process for natives to become religious leaders was expedited by the missionaries. Integration of Guatemalan religious leaders allowed the missionaries to infuse Guatemalan culture with Protestant principles. The congregations were also transformed into an interactive social experience with singing and dancing that reinforced religious values, a stark contrast to the authoritative and conservative Catholic religious experience. Guatemalan religious leaders became role models on how to overcome obstacles and improve their quality of life. Most importantly, the community was able to see the transformation of Catholics who converted to Evangelicalism. They were able to gain access to resources such as owning a bigger house, driving a nicer car, and wearing nicer clothes. Newly converted natives shared personal stories on how they overcame

obstacles (e.g., drug use, unemployment) thanks to the guidance of Protestant values. Religious fundamentalists preached the gospel and emphasized the difference Protestant values made in their lives.

Fundamentalists in Guatemala believe that the state's corruption is due to a lack of religious ideals. Protestant values are viewed as the essential element in creating a productive society. "The Gospel of Wealth decreed that wealth was God's way of rewarding the diligent and honest, while poverty was punishment for idleness and sin" (Burnett 1998, p.133). Transition into an industrial capitalist society is dependent on Protestant missionaries. "…American missionaries went to Guatemala not only to save individual souls but to correct the course of Guatemalan society" (Burnett 1989, p.133). Fundamentalist missionaries are guided by the following Christian principles:

1) Inerrancy or biblical literalism, the belief that every word of the Bible is to be taken literally as the word of God
2) Conversion or the experience of being reborn in Christ
3) Evangelicalism, or the duty of the saved to spread the gospel
4) Apocalypticism or endism, the belief that the biblical book of Revelation describes the events that must come to pass for God's plan to be fulfilled. (Davis, 2006, p.267)

The foreign status of fundamentalists in Guatemala requires them to be cautious about the movement's development and avoid confrontation with the government. Guatemalan fundamentalists do not have an established enclave, but they reinforce religious ideology through each individual. The missionaries' flexibility in accommodating various populations is demonstrated in the Neo-Pentecostal and Evangelical groups (Stoll, 1994). Neo-Pentecostals are upper-class Catholics that embraced the American Protestant movement, which emphasizes that God monetarily rewards all faithful Christians (Stoll, 1994). Evangelical members are primarily Indian

and represent the other economic extreme and coming from poverty stricken rural areas. Both Protestant denominations have different needs that are being met by the missionaries through entrepreneurial workshops for Neo-Pentecostals or social services for Evangelicals. The main goal during a quiescent period for fundamentalists in Guatemala is to increase in number to prepare for the active period, which entails a battle to become the dominant political, social, and religious culture of the state. The following section explores the various characteristics of fundamentalism in Guatemala.

4.2.2. *Religious Enclaves*

An enclave has not been established in Guatemala and membership in a specific religious group tends to be fluid. You can find people who identify as Catholic, but are also involved in a Protestant congregation. The line between Catholics and Protestants is blurred and Protestant principles are upheld by Catholics (Stoll, 1994). Catholics participate in Neo-Pentecostal activities such as the *Hombres Cristianos* (Christian Men) (Stoll, 1994). "Full Gospel is so undemanding of Catholic members who continue to smoke cigarettes, wear crucifixes, and honor the Virgin Mary that dissidents eventually started a new network to uphold evangelical distinctives, the Hombres Cristianos (Christian Men)" (Stoll 1994, p.106). Upper-class Catholics are able to claim the Protestant born-again experience without the stigmas associated with evangelicalism (Stoll, 1994). Rural, poor Evangelicals are able to access the services (e.g., education, healthcare, literacy programs) provided by missionaries (Stoll, 1994). Most importantly, Guatemalans are able to start their own Protestant congregations such as the *pura guatemalteca* Protestants, which empowers the community (Burnett, 1989).

4.2.3. *Religious Response to Modernity*

Fundamentalists reinforce maintenance of religious beliefs and rely on religious text in understanding history, the present, and the future. Lazarus-Yafeh (1993, p.49) indicates that "…fundamentalists transform Scriptures into textbooks of contemporary history, predicting not only modern inventions and technology…but details of contemporary and future political events as well, turning them into eschatological details of the messianic era." The Bible teaches believers how to respond to society and events. Fundamentalists believe that modernity is the greatest culprit that has caused history to go bad (Hunter, 1993). Although modernity has been perceived as an evil toxin, fundamentalists have utilized technology (e.g., television, media, medical care) to advance their cause. Fundamentalists in Guatemala utilize radio and television to reach the masses and increase members of the Protestant movement.

Guatemalan fundamentalists reflect on historical events and emphasize that Protestant values caused the U.S. to become a modern nation. Fundamentalists believe that Guatemala's troubles are a result of the state not being founded on Protestant ideals (Hockenberry, York, & Jersey, 1992). Guatemala's failure to address the needs of people has provided a void that fundamentalists can fill. Social services have provided an opportunity for fundamentalists to interact with people and spread the gospel. The radio has also been a significant tool to reach the masses. Music entices one to listen and is a good approach to gain a captive audience (Hockenberry, York, & Jersey, 1992). The circulation of a publication entitled *Publicacíon Pro-Alfabitación (PAN)* is another example of fundamentalist utilization of modernity to spread Protestant values.

Technological advances provide an easy way for missionaries to reach out to the masses and spread the gospel.

4.2.4. *Manichean Beliefs*

Religious fundamentalists orchestrate initiatives such as creating a religious enclave for members to reinforce religious beliefs and values. The religious wall of virtue encourages conformity among its members, which dictates how one should respond to modernity and contrasting their religious lives with nonreligious members of society. Manichean beliefs reinforce a culture based on ideological exclusivity among Protestants by creating a dichotomy between the worthy (Protestants) and unworthy (non-Protestants). Fundamentalists believe that people suffer because they do not uphold Protestant values. The church reinforces Manichean beliefs through religious rhetoric and builds a community of members that share the same religious beliefs and values. Hunter (1993) states:

> In short, there is a certain proclivity among all fundamentalisms to base both religious authority and the rejection of modernity upon a literal reading of scriptural text. The significance of scripturalism is that it establishes very clear symbolic boundaries between good and evil, and right and wrong. It also establishes the criteria for distinguishing the faithful from the unfaithful and infidel. (p.36)

Fundamentalists develop a Manichean vocabulary to stress the extremes of benefits associated with an enclave and prevent members from venturing out to the dangers of society (Sivan, 1995). Guatemalan fundamentalists emphasize along with their American counterparts, believe that the Bible is the inerrant word of God truth and any conflicting information is false (Davis, 2006). Biblical literalism plays a key role in fundamentalism because the Bible is used as a guide for one's life and reinforces religious rhetoric. A dualistic frame of thought is created where anything that contradicts

or deviates from the Bible is considered implausible. Religious rhetoric creates a strong contrast between the saved and the condemned. Missionaries have made it clear that in order to succeed in life one must ward off evil temptation and come under the guidance of God (Stoll, 1994).

> The rhetoric of such prayer campaigns as "Jesus is Lord of Guatemala" – about curses and demons, prayer warfare and opening up skies so that God can rain down his blessings – provides a new moral language to interpret Guatemala's crisis, identify underlying causes, and suggest ways to deal with them. (Stoll 1994, p.109)

Neo-Pentecostals for example preach about how the Lord has changed their lives by helping them avoid evil temptations such as smoking and drinking alcohol (Stoll, 1994). A focus is placed on individual responsibility, where Guatemalan fundamentalists live by example and share their stories to willing listeners in the Pentecostal church as well as in the community (Hockenberry, York, & Jersey, 1992). Pentecostal churches headed by Guatemalans provide followers with a sense of hope for a better life. In addition, fundamentalists from the community that have gained greater economic resources since their commitment to Protestantism flaunt their material possessions (e.g., cars, clothing, jewelry) and preach that since they have devoted their lives to God they have been blessed with a better life. They become key recruiters by sharing their positive experiences with family members and persuade them to come to church (Hockenberry, York, & Jersey, 1992).

Explanations for disparities have also been provided as an approach for encouraging people to improve their lives. "Prosperity theology" has emerged stating that: poverty is due to sinful behavior and laziness; individuals are to blame for their current state of despair; and individuals should reap their material success with pride as a

consequence of their religious faith (Hockenberry, York, & Jersey, 1992). Manichean beliefs among Protestants, as well as other fundamentalists, promise a rewarding life for following Christian principles and condemnation for people outside of the fundamentalist community. Fundamentalists emphasize that disparities in Guatemala are due to a lack of Protestant values, Satan's influence among lost souls. God will bless faithful followers and condemn the undeserving. Davis (2006) explains how being born again saves an individual from Satan's influence:

> No real responsibility exists because one was under Satan's power when one did all those terrible things. That's how He works. He invades a soul like a thief in the night and under his spell we do all sorts of things that are against our nature. But once we let Jesus in we are cleansed. Born again. All before was the work of an otherness that invaded us. It is now burnt and purged away. We can of course feel remorse, but at the same time those we harmed should know that it was not really our doing. The cause is not in ourselves but in the virus that tried to destroy our soul. (p.279)

4.2.5. *Religious Experience*

Fundamentalism provides members with a sense of security and hope. The contrast between the religious enclave and the outside world emphasizes the positive and negative attributes of becoming a fundamentalist. Fundamentalism provides order in a chaotic world. Unlike the outside world if members reinforce religious ideals they will be rewarded in the afterworld. A community is forged where a clear identity is established and intimate relationships are encouraged to support one another on the right path. Members have a purpose in life and take part in fulfilling God's destiny.

Fundamentalists reinforce homogeneity among members. The past, present, and future are pre-determined and the answers lie in the religious text. An emphasis is placed on religious ideals and the enclave's holy crusade. Religious fundamentalists have perceived modernity as a plague that has been corrupting society's religious beliefs and

values. Although fundamentalists reject modernity, they embrace it when the benefits (e.g., recruiting additional members into their enclave) strengthen their initiatives. The sanctity of marriage is not valued as it used to be and there are higher divorce rates. Initiatives to legalize same sex marriage have threatened the American foundation of traditional beliefs and values. Legalized abortion has disregarded the gift of life, which goes against religious beliefs. The media has also played an influential role in reinforcing inappropriate behavior (e.g., sex, drugs) among youth. Overall, the fundamentalists' crusade is to save the world through religious ideology, which requires states to enforce religious rule over society.

A review of fundamentalism in Guatemala sheds insight into religious fundamentalists' intent to provide services to historically oppressed and highly vulnerable populations. The power elite (e.g., missionaries, service providers) impose their ideology on the population they are serving through both implicit and explicit means. Displaying religious relics or having clergy (e.g., priests, nuns) are explicit approaches in providing direct services to the community. An implicit approach may start with a neutral environment, but during the provision of services the provider may pray for the client or insist that employees are members of the religious enclave. The intent is to establish a homogenous community that reinforces similar religious beliefs and values as the Guatemala experience indicates. Conflicts arise when a vulnerable population is dependent on a provider for services (e.g., shelter, clothing, food, medical care). The literal belief of the Bible reinforces Manichean beliefs of us vs. them. A clear distinction is made between deserving and undeserving.

Limited resources make it impossible to select a service provider that accommodates one's cultural beliefs and values. Religious rhetoric does not condone behavior that places one at greater risk of HIV transmission (e.g., homosexuality, drug use, sex work), which creates obstacles for the service provider from effectively addressing risk behavior with vulnerable populations. Promoting abstinence, monogamy, and marriage reinforces a religious heterosexual patriarchy and does not tailor HIV interventions towards the target population. The U.S. government has allocated funding for FBOs to address HIV/AIDS in the community and continues to struggle with addressing behavior (e.g., homosexuality, drug use, promiscuity) that does not reinforce religious rhetoric.

4.3. *Separation of Church & State*

Faith-based initiatives give the impression of having altruistic motivations for providing services for highly underserved populations. An overview of fundamentalism in the U.S. as well as Guatemala sheds insight on religious organizations' ulterior motives for addressing the needs of underserved populations, which is to gain the trust of the community and convert them. The overall goal of missionaries is to increase their members, become the dominant source of governance, and impose their religious beliefs and values to create a better society. Fundamentalists view God as the ultimate authority over man and the Bible as the inerrant word of God, a means for distinguishing the deserving from the undeserving. Religious organizations reinforce social stratification with God being the ultimate authority followed by religious leaders, clergy, congregation, and the general population.

In Guatemala, foreign missionaries are at the top of the hierarchy followed by Guatemalan religious leaders (i.e., gate keepers) in the community. Newly converted Evangelicals spread the gospel and save souls. A trickle down effect occurs with the power elite determining what beliefs and values to reinforce through religious rhetoric. The Gospel of Wealth provides clear implications for religious followers, stating that God rewards Evangelicals and Satan preys among the weak. Religious rhetoric reinforces an elite group of "saved souls" form the masses.

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.
> (U.S. National Archives & Records Administration, 1789)

The Bill of Rights clearly establishes a separation of church and state, but the faith-based initiatives enacted by the government fund a biased faith-based approach towards addressing HIV/AIDS. The President's Emergency Plan for AIDS Relief (PEPFAR) was a five year plan implemented by the U.S. government in 2003 that invested 18.8 billion to support initiatives addressing HIV/AIDS, tuberculosis, and malaria in low and middle income states (Office of U.S. Global AIDS Coordinator, 2009; Kaiser Family Foundation, 2011). PEPFAR was renewed in 2008 for an additional five years and currently focuses on HIV/AIDS programs. The U.S. Global AIDS Coordinator oversees activities to address HIV/AIDS, which allocated $39 billion (approximately 81%) out of $48 billion to address HIV/AIDS throughout 2009-2013 (Kaiser Foundation, 2011). The "United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008" (Lantos & Hyde, 2008) was designated to enhance and direct global initiatives. The global initiative is a collaboration of the state; USAID;

Department of Health and Human Services; CDC; Health Resources and Services Administration; National Institute of Health; Department of Labor, Commerce, and Defense; and the Peace Corps (Kaiser Foundation, 2011). The overall goals of PEPFAR (Office of U.S. Global AIDS Coordinator, 2009) are to: promote sustainable development; strengthen partner government response to health epidemics; expand prevention, care, and treatment programs; reinforce broader global health programs to maximize effectiveness of healthcare systems; and improve service delivery to maximize designated outcomes. PEPFAR is a landmark initiative taken by the U.S. government towards funding global initiatives addressing health disparities in low and middle income states. The program has placed the U.S. as the primary investor in addressing global health disparities.

PEPFAR has had a significant impact on addressing the global HIV/AIDS pandemic, but despite its advances the program has also been under scrutiny due to contractual agreements for partner states to reinforce abstinence based interventions for young people and to eradicate prostitution. Stipulations imposed by contractual agreements are ideological, which for example have conflicted with Brazil's approach that seeks to ensure human rights for everyone including universal access to healthcare and treatment regardless of being a sex worker. The Brazil National AIDS Commission refused the stipulation and rejected $40 million from USAID because it excluded sex workers from accessing HIV prevention services (Middleberg, 2006). Middleberg (2006) indicated the following stipulations for states to receive funding and eradicating prostitution:

> No funds made available to carry out this Act [US Leadership against HIV/AIDS, Tuberculosis, and Malaria Act], or any amendment made by this Act, may be used to promote or advocate the legalization or practice of prostitution or sex trafficking.
>
> No funds made available to carry out this Act, or any amendment made by this Act, may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking. (p.4)

The Act also imposed an abstinence based stipulation in addition to the eradication of prostitution, which states that in order for states to receive aid they must adhere to the following:

> Section 403 of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7673) is amended—
> (1) by amending subsection (a) to read as follows:
> ''(a) BALANCED FUNDING REQUIREMENT.—
> ''(1) IN GENERAL.—The Global AIDS Coordinator shall—
> ''(A) provide balanced funding for prevention activities for sexual transmission of HIV/AIDS; and
> ''(B) ensure that activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction are implemented and funded in a meaningful and equitable way in the strategy for each host country based on objective epidemiological evidence as to the source of infections and in consultation with the government of each host county involved in HIV/AIDS prevention activities.
> (Lantos & Hyde 2008, p.49)

The "ABC" (Abstinence, Be faithful, and correct and consistent Condom use) approach to HIV prevention has been highly scrutinized as a short-term solution that does not prepare young people (ages 10-24) with the skill set needed when they become or if they are currently sexually active. PEPFAR (2005) emphasizes that it is committed to providing evidence-based interventions to successfully accomplish its designated objectives. "It is important to note that ABC is not a program; it is an approach to infuse throughout prevention programs" (PEPFAR 2005, p.2). Abstinence is not limited to youth that have never engaged in sex. The abstinence approach encourages sexually

active youth to embrace a "secondary abstinence," which encourages sexually active youth to abstain from sex until marriage.

PEPFAR (2005, p.2) further states: "Abstinence programs encourage unmarried individuals as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections." PEPFAR (2005) emphasizes that ABC must be balanced in the prevention strategy in order to fund a partner state. PEPFAR also acknowledges that cross-generational sex and sexual activity occurs among young people through both choice and coercion, but that is why a "C" (condom use) component is reinforced for target audiences. Cross-generational sex refers to a sexual encounter between an older and younger individual. The younger person may pursue sexual relationships with older people as a means for sustenance (e.g., money, food, shelter, clothing) and it may be reinforced in a culture with limited access to resources. ABC interventions acknowledge this limitation and require the provider to address condom use among high-risk groups such as young females. Inequality becomes the root of multiple problems that limits power for the young person to influence the older person to use a condom. An emphasis is placed on the individual to negotiate risk reduction with the sexual partner, but disregards the influence social determinants (e.g., education, employment, housing, healthcare) have on one's vulnerability to HIV/AIDS.

PEPFAR indicates that abstinence is the only 100% effective approach of protecting oneself from an STI. Research studies have shown that "…latex condoms provide approximately 80-90 percent protection, *when used consistently*" (PEPFAR 2005, p.4). The initial framework policy for PEPFAR in 2003 was to allocate 20% of the funding to HIV prevention, of which 33% must be spent on abstinence until marriage

programs (Sessions, 2009). The Reauthorization Act (Lantos & Hyde, 2008) removed the allocation of 33% of funds to focus on abstinence based programs, but requires a "balanced funding requirement" for the Global AIDS Coordinator to ensure that programs promote abstinence and delay of sexual debut as well as monogamy, fidelity, and partner reduction. PEPFAR (2005) indicates:

> Implementing partners must take great care not to give a conflicting message with regard to abstinence by confusing abstinence messages with condom marketing campaigns that appear to encourage sexual activity or appear to present abstinence and condom use as equally viable, alternative choices. Thus, marketing campaigns that target youth and encourage condom use as the primary intervention are not appropriate for youth, and the Emergency Plan [PEPFAR] will not fund them. (p.5)

Encouraging "high-risk" people to use condoms reinforces stigmas associated with the target population (e.g., MSM, IDU, CSW) and discourages one from utilizing condoms. For example, HIV interventions that restrict condom distribution to sexually active youth alerts the community that they are sexually active, but if condoms are distributed to all youth it removes the stigma of having a condom and being sexually active.

PEPFAR (2005) also acknowledges that in order for HIV prevention interventions to be highly successful, programs must apply local cultural values that to address the needs of the community. The U.S. government places an emphasis on empowering people to play an active role, but limitations are reinforced when cultural beliefs and values from the community conflict with designated guidelines. Brazil for example has recognized the complexity of reducing the risk of exposure to sexually transmitted infections and acknowledges the power dynamics that prevent an individual from making the best decisions to protect themselves. Therefore, Brazil has refused to reinforce ABC as an approach to HIV prevention, which almost jeopardized USAID funding for the

state. Brazil has been a maverick in its response to HIV/AIDS and has beaten the odds despite skepticism imposed by the power elite. The following chapter will place an emphasis on Brazil's programs and how it became one of the most effective states in curtailing the spread of HIV.

Excluding young people from HIV interventions impedes their ability to develop the necessary skills to negotiate risk reduction with their sexual partners and their ability to properly use condoms. Ignorance related to sexual reproduction among youth does not discourage them from having sex, but it does cause them to rely on their peers for information and resources. Young people are in a vulnerable state of development, which may involve exploration of their sexuality and drug use. Proper guidance is essential for empowering youth to make wise decisions and approach adults for assistance that is free of judgment.

> More than half of all sexually transmitted infections, other than HIV, (more than 180 million out of a global annual total of 340 million) occur among young people aged 15 to 24 [based on 2008 data]. Yet most young people still have no access to sexual and reproductive health programs that provide the information, skills, services, commodities, and social support they need to prevent HIV, In fact, many laws and policies go as far as to exclude young people from accessing sexual health and HIV-related services, such as HIV testing and counseling, the provision of condoms, and age-appropriate sexuality and HIV prevention Education.
> (UNAIDS, 2010, p.5)

The UNAIDS (2010) report on young people highlights significant obstacles encountered by young people that are heightened by PEPFAR initiatives to promote abstinence based programs and its refusal to financially support campaigns for condom use among youth. UNAIDS (2010, p.8) states that according to the Commission on AIDS in Asia, "…more than 90% of resources for young people as a group are spent on lower-risk youth, who account for less than 5% of infections." The renewal of PEPFAR

in 2008 has emphasized the need for enhanced HIV programs that use a combination of biomedical, behavioral, and structural interventions; but stipulations (e.g., abstinence based programs, refusal to fund condom use campaigns) imposed on targeting youth hinders initiatives in addressing risk behaviors among youth. Highly marginalized populations (e.g., substance users, sex workers, MSM) are at greater risk of exposure to HIV and lack the essential resources to make wise decisions to prevent HIV transmission. A focus on structural level interventions requires stakeholders (e.g., government agencies, funding agencies, international agencies) to collaborate towards initiatives that remove stigmas and obstacles for highly marginalized populations from accessing essential services.

Summary

The current state of the economy in addition to the continued spread of the HIV pandemic requires each state to consider best practices for curtailing the epidemic in another state. The first step involves the government becoming knowledgeable about the HIV/AIDS epidemic in their state and determining the scope of the problem (i.e., generalized or concentrated epidemic). A generalized epidemic has the greatest impact of HIV prevalence rates among the general population, which tends to have a greater burden on females and is concentrated in the region of Sub-Saharan Africa (USAID, 2009). A concentrated epidemic has the greatest impact of HIV prevalence rates among populations engaged in "high-risk" behavior, which includes: MSM, IDU, and CSW (USAID, 2009). Significant obstacles exist within certain states when it comes to acknowledging and addressing the needs of "high-risk" behaviors, which may be fueled by religious rhetoric that condemns homosexuality, substance use, and/or adultery (e.g.,

sex work). Some states also do not want to acknowledge sexual activity among youth and/or restrict youth from accessing information related to reproductive sexual health. Government policies criminalizing marginalized populations such as homosexuality, commercial sex work, and needle exchange programs fuel the HIV/AIDS epidemic and cause marginalized populations to become even harder to reach. They also prevent the development of HIV interventions that address the needs of the community. It is important that a government be as objective as possible when monitoring and evaluating the HIV epidemic in order to enhance services through community based organizations including FBOs. Integrating religious ideology into politics creates a government that reinforces biased support for "deserving" groups of their society.

PEPFAR has good intentions towards addressing the HIV/AIDS pandemic. Unfortunately the U.S. government has not acknowledged the problems with the existing policies/initiatives. It has refused to work with partner states and threatened to withdraw financial support when the partner (i.e., Brazil) does not comply with U.S. policies. PEPFAR (Office of Global AIDS Coordinator, 2009) indicates the significance of combining biomedical, behavioral, and structural interventions to address HIV/AIDS; but reinforcing abstinence based programs and limiting access to resources (e.g., condoms, sexual education) exacerbates obstacles for youth and marginalized populations from developing the essential skills they need to reduce risk behavior.

FBOs have a significant following within local communities and can provide instrumental support towards enhancing and developing innovative approaches in curtailing the HIV epidemic, but local governments must be objective when evaluating goals and objectives. Local governments are encouraged to consider the strategic

framework proposed by UNAIDS (2009, refer to Appendix C) when participating with FBOs. The strategic framework suggests that a government collaborate with a FBO to utilize existing resource and empower the target population with essential tools in curtailing the HIV/AIDS epidemic.

5. HIV/AIDS & Brazil

A special emphasis on the HIV/AIDS epidemic in Brazil is warranted due to their innovative approach to overcoming opposition from the power elite (e.g., World Bank, Brazilian government, international pharmaceutical companies). An overview of lessons learned from Brazil will provide a useful perspective for the U.S. to consider for decreasing HIV prevalence rates. This chapter will review the evolution of HIV/AIDS in Brazil and the role activists have played in influencing the government's response to the epidemic. de Ferranti's (2004) emphasis on the ways that political and social factors reinforce inequality will be explored in relation to the HIV/AIDS movement in Brazil.

This chapter will look at inequality in Latin America and Brazil and give an overview of HIV/AIDS in Brazil. The section on the HIV/AIDS social movement will shed insight on how the disease has spread among various populations and look at the state's political response. The section on vulnerable populations provides insight into the obstacles that people encounter due to inequality and the factors that might increase their susceptibility to HIV/AIDS. on the partnership between Candomblé religious leaders and the Brazilian government to develop a faith-based HIV intervention for historically oppressed and highly marginalized populations warrants attention due to its effectiveness in integrating spiritual beliefs with HIV risk reduction among a highly vulnerable population. The final part of this section explores how Brazil has revolutionized initiatives taken by low and middle income states to access HIV/AIDS medications.

Brazil is the largest country in Latin America and has been rated as the top offender of inequality. Social structures were created and reinforced to protect the interests of the elite. During the early 1980s the state transitioned from a dictatorship to a

democratic society. Brazil identified the first case of AIDS in 1980 during the time it was establishing a democratic system of government. The social movement in Brazil has been very impressive in ensuring that the state takes appropriate action to address the needs of people living with HIV/AIDS. The transition of the HIV/AIDS epidemic from males to females and poverty stricken communities has caused Brazil to reevaluate its initiatives and provide appropriate services to prevent the epidemic from spreading.

5.1. *Inequality in Latin America*

Hoffman and Centano (2003) define inequality as the disproportionate distribution of resources across society. In essence, resources (e.g., money, property, education, healthcare) are controlled by a small percent of people in power (i.e. power elite), who decide how and within which limits resources will be disseminated to society. The wealthiest (share of the top 10% in total income) receives between 40 to 47% of total income in Latin America (de Ferranti et al., 2004). Among Brazil, the wealthiest (top 10%) receive a share of 42.5% in total income, which is a stark contrast with the lower class (lowest 20%) who receive a share of 3.3% in total income for 2009 (World Bank, 2011). The concentration of wealth among the top 10% of the population sets Latin America apart from other developing states at the same level; the GINI index for the remaining population is the same when compared to other similar states (Hoffman & Centano, 2003). The GINI index is a measure used to determine levels of inequality based on distribution of resources within a country, zero indicates that there is perfect equality and 100 indicates that there is perfect inequality (Bacon et al., 2005).

Even though Brazil decreased its GINI index from 63 in 1989 to 54 in 2009 (World Bank, 2011), it remains as one of the top states in Latin America with the greatest

inequality. The Human Development Index (HDI) measures the overall well-being of the population, which is a combined measurement of health, education, and income (UNDP 2009). Brazil's HDI has increased from .649 in 2000 to .699 in 2010 and it has ranked globally at 73rd and regionally at 11th place (UNDP, 2011). Inequality still continues to be a significant problem in Brazil, but President Lula da Silva has made an admirable effort towards reducing inequality in Brazil. Since President da Silva inauguration in 2003 and reelection in 2006 he has taken significant strides by slashing the percentage of the population living below $2 a day from 21.2% in 2004 to 12.7% in 2007 (UNDP, 2009). The World Bank (2011) also indicates that the percent of the population living below $2 a day has decreased from 10.4% in 2008 to 9.9% in 2009.

Multiple factors (e.g., employment, education, property) have an effect on inequality in Latin America, but it is important to take into account the historical context that has influenced the development of the region. Social structures that reinforced inequality and withheld resources from the larger society were established in Latin America during the colonization period (de Ferranti et al., 2004; Hoffman & Centano, 2003; Ramos, 1996; Service, 1955). Colonizers inhabited Latin America and harnessed the resources of the land through the enslavement and/or exploitation of the native Indians (Ramos, 1996). The racial makeup of the inhabitants of Latin America changed once the colonizers took control of the land. Hoffman and Centeno (2003) indicate that ethnic identity influences access to resources and increases disparities among Indian and Black Latin Americans. Brazil was one of the last countries to abolish slavery in 1888. "Such relational inequalities have had major effect on processes of socialization,

collective expectations, and daily interactions, in turn affecting behaviors and conditions related to school, work, and other interactions" (de Ferranti et al., 2004, p.127).

de Ferranti and colleagues (2004) emphasized that political and social factors reinforce inequality in Latin America. States have played a regressive role in providing public goods (e.g., education, health, water, sanitation) for the poverty stricken population (de Ferranti et al., 2004). Elites in Latin America have the resources to protect themselves and influence the state to establish policies that protect their interests (de Ferranti et al., 2004). Social structures were created and maintained to reinforce the interests of the dominant group (e.g., colonizers, elite), which resulted in "truncated" systems that exclude the most vulnerable (de Ferranti et al., 2004). "Wealthy groups again have greater options for either exerting influence on public service provisioning for themselves or opting out of private provision" (de Ferranti et al., 2004, p.123). de Ferranti and colleagues (2004) emphasize that in order for a change to occur in Latin America it must be made from inside as well as outside of the social structures.

The colonization of Brazil established an oligarchy, which strengthened the power elites' hold over resources and continues to monopolize politics and business in Brazil today (Gryzbowski, 1990). Gryzbowski (1990) identifies three significant social movements in Brazil that challenged the state supported model of agricultural development: 1) displacement and/or access to land; 2) agricultural wage workers; and 3) subordination of peasants. The rural movement had a significant influence in the democratization of Brazil by becoming a significant counterweight against the power elite and encouraging active participation in the political system (Gryzbowski, 1990). Latin America's current democratic government offers potential for decreasing social

inequality through social movements that pressure the government to decentralize resources (de Ferranti et al., 2004). "If the subordinated classes have – or can develop – organizations strong enough to control the state apparatus, they can take advantage of the weakening of the dominant classes, and advances toward democracy become more likely" (Rueschemeyer, 1992, p.71). Inequality is not an isolated problem for low and middle income states, but also occurs among high income states as the historical perspective on HIV/AIDS demonstrates in the U.S. The start of the HIV/AIDS epidemic in Brazil was during a tumultuous political climate when the state was in transition from a dictatorship to a democracy. The social movement during this political transition was grounded in a human rights approach, which influenced the development of new government policies addressing social disparities in the state. Therefore, a brief review is warranted on the development of international human rights and the implications for giving historically oppressed and highly marginalized populations access to resources and the fundamental right to fully develop as a person.

5.2. *Universal Declaration of Human Rights (UDHR)*

The atrocities caused by the holocaust and World War II were the catalyst for the international community to come together in 1945 and establish the United Nations (UN) as an effort to promote peace and protect the rights of vulnerable populations. The UN believed that human rights were fundamental freedoms that every individual is entitled to in order to fully develop personal characteristics (e.g., intelligence, conscience, spirituality, talents) as a human being regardless of race, sex, religion, political and/or opinions.

> Human rights are universal and apply to all persons without discrimination. Respect for individual rights needs to be upheld at all times irrespective of circumstances or political systems. The rights of any particular individual or group in any particular circumstances can be restricted only if they threaten to curtail similar or comparable rights of others. (OHCHR, 1994, p.4)

> Universal human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups. (OHCHR, 2011)

The newly established UN provided guidelines in 1948 known as the Universal Declaration of Human Rights (UDHR) to reinforce the basic rules of freedom for people in civil, political, economic, social and cultural rights (OHCHR, 1994). The UDHR is available in over 250 languages and is composed of declarations – a set of general principles or standards of human rights and conventions – defines one's specific rights and limitations. Overall, the UDHR has 30 articles that articulate the basic rules and freedoms for all people. Two additional covenants were included to the UDHR in 1966 to clarify and describe rights related to: 1) Civil and political rights; and 2) Economic, social, and cultural rights (OHCHR, 1994). The covenants address significant rights (e.g., security, not to be tortured, voting, housing, work, health) that protect people, which people may take for granted. Additional conventions have been implemented to eliminate racial discrimination, sex inequality, torture and inhuman or degrading treatment or punishment. The conventions provide protection to historically oppressed and highly vulnerable populations such as females, children, indigenous populations, refugees, and migrant workers.

The following section reviews the history of the HIVAIDS epidemic in Brazil and the influence that social movements and human rights had in pressuring the state to take a more active role. The section demonstrates how inequality has affected the evolution of HIV/AIDS and the provision of services in Brazil.

5.3. *HIV/AIDS Epidemic in Brazil*

Brazil is the largest country in Latin America with a population of approximately 199 million (CIA, 2010) and an estimated 730,000 people living with HIV in 2008 (UNAIDS 2010). HIV prevalence has remained stable at 0.6% as of 2000 (UNAIDS 2010). The epidemic in Brazil has progressed into the following: Phase I – Men who have Sex with Men (MSM) and blood transfusion recipients; Phase II – Injection Drug Users (IDU); and Phase III – women and poverty-stricken communities (Berkman et al., 2005; Bacon et al., 2004). Currently the population with the greatest risk of HIV is women and poor people through heterosexual transmission (Berkman et al., 2005; Bacon et al., 2004). Among males and females the age cohort with the greatest numbers of AIDS cases are people who are 30 to 49 years old (Brazilian Ministry of Health, 2006). AIDS incidence continues to impact males at a greater rate, but the gap between males and females is narrowing. The male to female ratio was 2:1 in 2002 (Bacon et al., 2005). A better understanding of the population's knowledge of HIV transmission and sexual behavior provides useful information about Brazil's response in addressing HIV/AIDS. Knowledge of HIV transmission is high among Brazilians; 90.8% of people aged 15-54 indicate that sexual intercourse is a mode of HIV transmission (Monitor AIDS, 2005). Within the same population 67.1% were able to correctly identify multiple ways in which HIV is transmitted (Monitor AIDS, 2005). Sexual intercourse was not distinguished by

sexual acts and it would be interesting to explore if there are any differences on knowledge of HIV transmission through oral, anal, and vaginal sex. Reports on age of sexual debut differ among Brazilians, with some indicating that age of first sexual encounter (among people aged 25-54) was 17 years old, and others (people aged 15-24) reporting that it was 15 years old (Monitor AIDS, 2005). Sexual activity during their lifetime was slightly lower (73.9%) for 15-24 year olds compared to 25-54 year olds (97.7%) (Monitor AIDS, 2005). Another study found that marginalized youth were 13 years old at the time of their first sexual encounter (Peres et al., 2006). It would be interesting to collect epidemiological data on youth who are 13 and 14 years of age to gain a better understanding of the population.

Younger people (15-24) in Brazil also used condoms more often during last sexual encounter (57.3%) and reported regular condom use with any partner (39%) (Monitor AIDS, 2005). People 40 to 54 years old reported the lowest levels of condom use at last sexual encounter (22.3%) and regular condom use with any partner (16.1%) (Monitor AIDS, 2005). A recent study conducted in the U.S. by Reece and colleagues (2010) indicated that condom use was higher among adolescents (14-17) than adults (18 and older). The study (Reece et al., 2010) also indicated that Latino and black males reported greater condom use when compared with white and "other" males. Condom use overall seems to be greater among youth in Brazil and the U.S., but the disproportionate HIV prevalence rates among historically oppressed and highly marginalized populations places Brazilian youth at greater risk of HIV exposure.

5.3.1. *Social Movements Response to HIV/AIDS*

Brazil deserves special recognition in our understanding of the HIV/AIDS epidemic in the U.S. Brazil is an upper-middle income state (World Bank, 2011), that has great disparities due to inequality and it has responded to the HIV/AIDS epidemic in unique ways, but has not curbed the epidemic among marginalized impoverished communities. The odds were significantly against Brazil's ability to effectively respond to HIV/AIDS. The World Bank in 1990 predicted that 1.2 million people in Brazil would acquire HIV by the year 2000 (Berkman et al., 2005). Fortunately Brazil had an estimated 730,000 people living with HIV in 2008; to some extent because of the action taken by social movements in the state. The following section will review how social movements pressured the state to developing policies that address HIV/AIDS and prevent the epidemic from escalating.

Prior to focusing on the social movement, it is important to acknowledge Brazil's history. Brazil was under military dictatorship during the 1960s to early 1980s (Petersen et al., 2005). During the 1980s there were social movements in urban as well as rural areas that resulted in the democratization and reform of Brazil (Petersen et al., 2005). A sense of citizenship reinforced solidarity among Brazilians towards advocating for human rights (Berkman et al., 2005). Once the democratic state became established, some activists played influential roles in the government and others established Non Government Organizations (NGO) (Galvão 2005). Similar to the U.S., Brazil's HIV/AIDS movement was galvanized by privileged gay white men who were threatened by the epidemic. Brazil's social movement took an innovative approach and advocated for access to healthcare as a human right. HIV fostered an invested interest among

privileged gay white men to pressure the government into investing health care for the entire population including poverty-stricken populations.

5.3.1.1. *Phase I: MSM & Blood Transfusion Recipients*

The first wave of PLWHA in Brazil was an affluent population composed of MSM and blood transfusion recipients (Petersen et al., 2005). During the early 1980s, the Brazilian government proposed to address HIV/AIDS by enforcing mandatory testing and the quarantine of PLWHA (Galvão, 2005). Activists that played essential roles during the democratization of the state mobilized and pressured the government into taking appropriate action in addressing the epidemic (Galvão, 2005). Biehl (2004) indicates that 79% of PLWHA in 1985 had obtained a high school or college education. NGOs focused on HIV/AIDS were established and played a significant role in the movement, such as: GAPA (AIDS Prevention and Support Group) founded in 1985, ABIA (Brazilian Interdisciplinary AIDS Association) founded in 1986, and *Grupo Pela Vidda* (Group for Life) founded in 1989 (Berkman et al., 2005). In addition to NGOs addressing HIV/AIDS, research was developed to focus on vulnerability as a factor influencing one's exposure to HIV (Galvão, 2005). Brazil's research initiatives have yielded more information than any other country in Latin America, which has supported the social movement's advocacy for the rights of PLWHA. HIV/AIDS activists were able to demonstrate that human rights violations increased one's susceptibility to HIV (Galvão, 2005). In 1987, the government retracted the proposal of mandatory testing and quarantine of PLWHA (Galvão, 2005).

A significant step forward for activists occurred in 1988 when the state drafted the new constitution and granted universal healthcare (Galvão, 2005). Universal health care

was influenced by the *sanitary reform movement*, which was established as a coalition among multiple groups (e.g., healthcare workers, academics, trade unions, churches), which focused on access to healthcare as a human right (Berkman et al., 2005). Successors of the *sanitary reform movement* obtained prominent positions in the Ministry of Health (Berkman et al., 2005). The dictatorship had caused many groups to suffer and the social movement towards democracy reinforced their solidarity and significance of human rights (Berkman et al., 2005). The government established the *Sistema Único de Saúde* (SUS) to provide access to healthcare for Brazilians, which evolved from the *sanitary reform movement* (Berkman et al., 2005). In addition to free healthcare, in 1991 the government began providing limited access to azido-deoxythymidine (AZT) medications for HIV such as zidovudine (Petersen et al., 2005).

Throughout 1991 and 1996 PLWHA filed class action law suits against the Brazilian government for access to healthcare and medications (Galvão, 2005; Petersen et al., 2005). The constitution was an instrumental tool in corroborating a plaintiff's case that the state should provide access to healthcare and medications for HIV/AIDS patients. A significant catalyst for holding the state accountable was the activists who provided specialized legal support for PLWHA (Berkman et al. 2005). In addition, Brazil's court rulings were efficient towards addressing cases regarding access to healthcare for PLWHA (Berkman et al., 2005). In 1996, Brazil passed a federal law to provide access to medications at no cost for PLWHA (Galvão, 2005; Petersen et al., 2005). The HIV/AIDS epidemic is similar to the U.S.; the first phase of the epidemic was among MSM, followed by IDUs, and poverty stricken communities. The following section will

review the spread of HIV/AIDS among IDU as well as historically oppressed and marginalized populations in Brazil to shed insight on the epidemic in Brazil.

5.3.1.2. ***Phase II: Injection Drug Users (IDU)***

The HIV epidemic began to spread among other populations and the next phase included IDUs. Injection drug use began to rise in the 1980s and it was influenced by greater drug trafficking at the Brazilian border (Berkman et al., 2005). As injection drug use increased, rates of HIV infection began to spread among the general population. Initial attempts to provide services for IDUs were prevented by the Ministry of Justice (Berkman et al., 2005). Introduction of needle exchange programs caused great tension between public health officials and the Ministry of Justice, which threatened to arrest anyone promoting needle exchange services (Berkman et al., 2005). A taskforce with members from the Ministry of Health and Ministry of Justice was created to develop a national response on IDUs and HIV transmission (Berkman et al., 2005). Throughout 1994 and 1998 the Ministry of Health began to implement needle exchange programs (Bacon et al., 2005). In 1998, AIDS activists succeeded in legalizing needle exchange programs (Berkman et al., 2005).

AIDS incidence for IDUs seemed to have stabilized among MSM in 1992 (refer to Appendix B: Table 2). Harm reduction programs have been successful in reducing HIV transmission among IDUs by encouraging them to change their drug use habits, such as alternative forms (i.e., inhaling, smoking) for using crack (UNAIDS, 2006). An emphasis is placed on social structures and how people in power avoid a social problem such as HIV/AIDS among a highly marginalized population (e.g., incarcerated men, MSM). Prisoners are held captive by the government for violating the law, but prisoners

are entitled to human rights regardless of their crime. The human rights stipulation indicates that people who are a threat to society can have their freedom restricted to ensure the safety of others. The government must determine how to maintain a drug free environment and prevent the spread of HIV/AIDS in the prison. The prison system does not condone sexual activity or drug use in the prison, which causes them to turn a blind eye and wash their hands from making a problem worst (e.g., spreading HIV/AIDS). A recent study exploring risks among male IDUs found that incarceration and unprotected sex with men increased susceptibility to HIV, 37% of male IDUs were infected with HIV (UNAIDS, 2006). In addition, 26% of male IDUs reported unprotected sex with other men in exchange for money (UNAIDS, 2006). Drug use and homosexual activity (coerced or consensual) fuel the spread of HIV/AIDS within the prison system, a problem that other states struggle with as well. Prisoners are entitled to an environment free of danger and access to resources (e.g., drug rehabilitation, condoms) to protect themselves when they are being held captives by the state.

5.3.1.3. ***Phase III: Women & Poverty Stricken Communities***

As AIDS incidence began to stabilize for MSM and IDUs in 1992, heterosexual transmission took a different path (refer to Appendix B: Table 3). Phase III emerges with the populations at greatest risk being women and poverty-stricken communities, with HIV infection occurring primarily through heterosexual transmission. Heterosexual transmission became the primary mode of exposure category for HIV in 1993. AIDS incidence via heterosexual transmission reached an all time high for males 13 years and older in 1998, and for females 13 years and older in 2002 (Brazilian Ministry of Health, 2006). AIDS incidence in Brazil by income is not available, but educational level is used

to determine the rate of HIV/AIDS among poverty-stricken populations. As Table 3 (Appendix B) demonstrates, AIDS incidence in 1989 among people (13 years of age and over) that did not complete high school began to exceed the incidence among people that did complete high school. The data demonstrates implications social structures (e.g., academic institutions) have in reinforcing social disparities among vulnerable populations. Educational attainment is a significant social determinant that influences one's quality of life, which in the case is an inverse relationship between education and HIV transmission. Between 1989 and 1998 there was approximately 87% increase in AIDS incidence among people (13 years of age and over) that did not complete high school (refer to Appendix B: Table 3). A study reported that the greatest increase in HIV prevalence was among nonworking men (18.9%) compared with working men (8.6%).

There has been a 44% increase in HIV prevalence rates among females between 1996 and 2005 (Brazilian Ministry of Health, 2007). Brazil realized the significant threat HIV/AIDS had among females and partnered with UNFPA, UNIFEM and UNICEF to develop interventions for females (Brazilian Ministry of Health, 2007). The interventions will emphasize a healthy life and greater self-esteem to reduce susceptibility to HIV (Brazilian Ministry of Health, 2007). The literature has not specified strategies targeting poverty-stricken communities, but the available information indicates that access to healthcare and adherence to medications are significant issues to consider when addressing the needs of the population (Bacon et al., 2005). Despite the limited information on poverty-stricken communities in Brazil, attention has been given to vulnerable populations and their susceptibility to HIV/AIDS.

5.4. *Vulnerable Populations*

> The poorest and marginal are here socially included through a public dying, as if their deaths had been self-generated. I mean: these abandoned only become partially visible in the public health system at the end of life and are then traced as "drug addicts," "robbers," "prostitutes," or "noncompliant," practices and labels that allow them to be blamed for their dying. (Biehl, 2004, p.120)

Significant challenges remain in preventing the epidemic from continuing to spread among people that are poor and have limited access to resources (e.g., education, employment, housing, healthcare). Biehl (2004) conducted a study on the AIDS unit of Salvador, Bahia's state hospital. A total of 571 AIDS death certificates issued between 1990 and 1996 were reviewed to get a better understanding of AIDS among poor people (Biehl, 2004). Among the sample (571 AIDS death certificates), 26% of the death certificates were accounted for the government's epidemiological surveillance and 52% died during their first hospitalization (Biehl, 2004). PLWHA that were homeless, poverty stricken, and/or substance abusers were found to have greater health disparities and were less likely to adhere to medical treatment for HIV/AIDS (Biehl, 2004). Social structures in Brazil addressing health related issues among PLWHA disregarded services targeted for highly marginalized populations, but accounted for them in epidemiological surveillance system at the time of an AIDS related death. Biehl (2004, p.119) raises an interesting question concerning "...how technical and political interventions make people invisible and how the dynamics affect the experience, distribution, and social representation of dying." Indicators selected for HIV/AIDS surveillance data sheds insight on how the epidemic spreads and affects various populations. Failure to account for household income and education level prevents one from determining who is accessing services and causes the poor and marginalized to be invisible (Biehl, 2004).

PLWHA that need services (*biomedical citizens*) require self-determination to demand access to healthcare and medications (Biehl, 2004), which is reflected in Phase I of the epidemic. The following section will provide greater information on Brazil's marginalized poor such as marginalized youth, Indians, and commercial sex workers.

5.4.1. *Marginalized Youth*

The "Marginalized Youth" category includes individuals between the ages of 12 and 21 that have a history of incarceration and/or homelessness (Bacon et al., 2005). A study conducted among marginalized youth in Brazil (1,122 males and 93 females) with an average age of 16 showed that 62% had less than a fourth grade education and 91% reported being sexually active (Bacon et al., 2005). The majority of the sample reported using the following drugs: 84% marijuana, 63% cocaine, and 56% crack (Bacon et al., 2005). Another study among marginalized youth indicated that 34% reported condom use during the last sexual intercourse and consistent condom use was lower: 9% in São Paulo, 19% in Pire Ferreira, and 27% in João Pessoa (Bacon et al., 2005).

A study of 279 incarcerated adolescent males in São Paulo showed that 98% were sexually experienced with their first sexual encounter at age 13 (Peres et al., 2002). Participants indicated that AIDS was not a concern due to other pressing issues such as survival (Peres et al., 2002). "Many believed that they will not live beyond 25 years of age and few of these adolescents believed they will be able to change their lives" (Peres et al., 2002, p.41).

5.4.2. *Indigenous Population*

The HIV/AIDS incidence and prevalence among the Indian population in Brazil is relatively low compared to the general population (Bacon et al., 2005). The Indian

population still deserves attention due to their proximity to cities and outsiders such as the military and miners (Bacon et al., 2005). Reported AIDS cases among Indians did not exceed 0.3% from 2000 to 2006 (Brazilian Ministry of Health, 2007). The majority of AIDS cases in 2001 were reported primarily among females (79.2%) and males (65.2%) residing in cities and mid-sized municipalities within the Center-West and North regions of Brazil (Bacon et al., 2005). Bacon and colleagues (2005) indicate that greater insight needs to be provided on risk factors related to poverty, commercial sex work, and alcoholism. HIV/AIDS was introduced into Indian communities by migrant miners who traded sex with Indian females for food and other resources (Bacon et al., 2005). Yanomani culture, for example, does not stigmatize females that make sexual arrangements with outsiders in exchange for resources (Bacon et al., 2005). *Fundação Nacional de Saúde,* with support from the Brazilian Ministry of Health, has funded (U.S. $43.3 million) NGOs to provide culturally sensitive HIV services (care and prevention) to Indian communities (Bacon et al., 2005).

5.4.3. *Commercial Sex Workers (CSW)*

Despite the escalated risks for HIV infection among CSWs, there is limited attention placed on this population. Interventions for CSWs should include male hustlers, transsexuals, and females. Each population experiences unique risk factors that require interventions that address the unique needs. A study among CSWs (434 transvestites and 96 male hustlers) in São Paulo found greater HIV prevalence rates among transvestites (40%) than male hustlers (22%) (Grandi et al., 2000). The median age among CSWs was 22 and 83% had a primary education or less (Grandi et al., 2000). The median age of the first sexual encounter was 13 for transvestites and 14 for male hustlers (Grandi et al.,

2000). The majority of CSWs (79% transvestites and 57% male hustlers) were born outside of São Paulo (Grandi et al., 2000). Male hustlers were (45%) more likely to report employment besides sex work than transvestites (26%) (Grandi et al., 2000). The finding of the research study (Grandi et al., 2000) provides useful information to identify risks associated with commercial sex work for males and transvestites and tailor HIV interventions to specifically address the needs of CSWs.

A study conducted among 295 female CSWs in São Paulo indicated that on average they had 70 clients a month and there was only one case of HIV (Peres et al., 2006). The sample reported condom use in 90% of their sexual encounters with clients (Peres et al., 2006). In addition, 75% of female CSWs had between 8 and 11 years of education (Peres et al., 2006). Consistent and correct condom use and education were protective factors. CSWs have expressed that their primary concern was police violence and citizenship (Hinchberger,2005). Once police violence dissipated, HIV became the primary concern among CSWs (Hinchberger, 2005).

5.5. ***Candomblé &HIV Interventions***

Candomblé deserves special attention due to its significance for a historically oppressed population (i.e., black Brazilians), how it has evolved throughout time, and the influence faith-based initiatives have in addressing the HIV epidemic among historically oppressed and highly marginalized populations. The colonization of Brazil resulted in a significant slave trade consisting primarily of the Yoruba people from West and West Central Africa (Johnson, 2002; Walker, 1990). Some of the slaves included Candomblé leaders and followers, which allowed the religion to flourish among the slaves and their descendents in Brazil (Walker, 1990). The Portuguese slave owners however, required

everyone to covert to Catholicism and restricted the slaves from practicing Candomblé. African slaves adapted the Catholic religion so it was consistent with their Candomblé beliefs and values yet gave the impression that they were being obedient (Walker, 1990). For instance the Catholic saints were seen as Orishas (Candomblé deities) in order to maintain their indigenous religious practices and not worship Catholic saints that resembled their oppressor (Walker, 1990). Walker (1990) states that:

> Although Brazil has been touted as a 'racial paradise,' progressive Brazilian scholars refer rather to the 'myth of 'racial democracy' in talking about the social politics of 'whitening' in which racial harmony was to be attained by physically breeding out the African phenotype, and transforming elements of Afro-Brazilian culture into generalized Brazilian folklore. (p.108)

Black Brazilian scholars have addressed the need for increased awareness of black pride and for the government to address the inequality between white and black Brazilians. The Black movement in Brazil has raised awareness of the African influence on Brazilian culture, which has increased the acceptance and popularity of the Candomblé and Capoeira[5] religions founded by African slaves.

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[5] A special on Brazil (PBS Wide Angle, 2007) states the following about Capoeira: "The prevailing account is that the 'warrior dance' began in the *senzala*, or slave house, where the African captives would gather to keep their culture alive through rituals. As the slaves in one plantation were often captured from several different African tribes, many times their only common language was rudimentary Portuguese and body gesture. Dance, drum, and chant became tools to strengthen bonds and create a sense of community. One of their dances is rumored to have been the *N'golo*, performed during the puberty rituals of the Mucope of southern Angola. The young men would dance, imitating zebras fighting, and the winner of the *N'golo* would be awarded a bride for which he did not have to pay a dowry.

Competitive festive dances were the perfect cover for developing the skills needed to kill the slave drivers. With time, the bonds of the senzala allowed the slaves to organize and plan their escape. Once on the run, they would practice their dance of resistance in forest

Globalization and technology has also increased the popularity of historically stigmatized cultural beliefs and values such as Candomblé and Capoeira. Candomblé has an intricate hierarchical system with designated roles and responsibilities for religious members (Herskovits, 1956). Candomblé groups are organized in *terreiros* (houses), headed by a priest or priestess (Herskovits, 1956; Walker, 1990). The priest/priestess is the leader of a *terreiro* responsible for the divinatory procedures and operation of the house. Candomblé followers are required to emulate sacred teachings in their daily lives (Herskovits, 1956; Walker, 1990). Walker (1990, p.103) states: "…Candomblé determines the very details of daily existence, from the colors of the clothes people wear to the foods they eat on a given day." Each member is united with an Orisha and must adapt his/her lifestyle to strengthen the bond with the Orisha (Herskovits, 1956).

Omolú for example is the Orisha of disease and pestilence with the following characteristics: greeting is *Atotoó*; designated day is Monday; designated colors are brown, white and red; elements are dirt and fire from the core of the earth; controls epidemics, cures illnesses, health, life and death (Candomblé, n.d.). Omolú is the most feared Orisha due to his control of infectious diseases and is considered the king of the land (Candomblé, n.d.). The children of Omolú are pessimistic, extremely stubborn, complain about their troubles, and always prefer to take the longest and most difficult path. They are likely to dissuade even the most optimistic individual (Candomblé, n.d.). They are not very bright or physically attractive and they like to annoy others (Candomblé, n.d.). Despite their limitations, they are extremely diligent and faithful

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clearings. These areas of low vegetation were called *caa-puera* in the Native-Brazilian tribal language *tupi*, and from there Capoeira evolved."

friends (Candomblé, n.d.). They are extremely happy, patient, and loving (Candomblé, n.d.). They will take the shirt off their back to please a person and would sacrifice money over pleasure (Candomblé, n.d.). Although they are not beautiful physically, their spirit attracts others (Candomblé, n.d.). An emphasis on Omolú and his children/followers provides insight into Candomblé and the implications for public health initiatives that can reduce health disparities in the community. HIV intervention and prevention programs in Brazil have integrated the role of the Orishas to educate religious followers on how to embrace a long healthy life by reducing their risk of HIV exposure and still enjoy sex. HIV programs have indicated that sex still remains an essential part of life, but due to HIV/AIDS people must take extra precautions to maintain their health.

The ministry of health in Brazil acknowledged the influence that Candomblé has in the lives of Brazilians partnering with Candomblé religious leaders to address HIV/AIDS in the community. The Odô-Yá Project in Rio de Janeiro, Brazil has been successful in incorporating HIV prevention through a faith-based perspective. The project was a collaboration between the Religious Institute of Education and the African-Brazilian Candomblé religious community. Silva and Guimarães (2000) state that the Religious Studies Institute used an opportunity to provide HIV prevention to the Candomblé religious community due to the following identified risks: sexuality is considered a source of pleasure and life; a sharp blade is used during a spiritual rite to make small cuts on its members; a large group of members are homosexual; and members are primarily poverty stricken, black and disenfranchised. On the positive side, Candomblé views the body as the "house of god" and reinforces the significance of "…education, physical health, psychic pains, and life in general" (Silva & Guimarães

2000, p 120). The Religious Studies Institute met with health professionals and Candomblé priests and priestesses to strengthen HIV prevention through an empowering religious context. Prior to the Odô-Yá Project, Candomblé members believed that the Orishas protected them from HIV. HIV prevention workshops were provided in the Candomblé communities and priests and priestesses participated in promoting HIV prevention through a religious context (Silva & Guimarães, 2000).

Special emphasis must be placed on the Odô-Yá Project due to its unique approach in promoting HIV prevention through an empowering faith-based perspective. While Condomblé is distinctive to a specific population it provides insight on conducting HIV preventions among disenfranchised populations. The same religious influences created Santería in the Caribbean slave population. Mexico was no exception and during the colonization *brujería* (witchcraft) integrated indigenous spiritual beliefs with Catholicism.

The Catholic Church has historically opposed the use of contraceptives and has frowned upon homosexuality, which has fueled the HIV/AIDS epidemic in Latin America as well as the U.S. Latinos still seek advice from spiritual healers (i.e., Condomblé, Santería, *brujería*) or convert to a fundamentalist religious group when their needs are not being met by the Catholic Church. The unique approach Brazil has taken in partnering with Condomblé religious leaders provides insight into initiatives that can be adapted to Latinos in the U.S. as well as Latin America.

PLWHA require access to medical treatment and medications. Escalating costs of medications and limited resources in low and middle income states have resulted in decreased access to HIV prevention and intervention programs for historically oppressed

and highly marginalized populations. The following section will review the implications of low and middle income states dependence on pharmaceutical companies in high income states for access to medications for HIV/AIDS and the radical initiatives Brazil has taken to ensure universal access to care for PLWHA.

5.6. *Access to Medications in the Developing World*

Low and middle income states faced several barriers when attempting to access HIV medications in the 1990s. Limited resources were allocated to prevention and treatment efforts at the international level (Galvão, 2005). "In the 1990s, The World Bank did not favor a policy of providing AIDS medicines to developing countries" (Galvão 2005, p.1113). International experts were also hesitant to provide HIV medications to low and middle income states for fear that a resistant HIV strain would develop from people failing to adhere to their medication regimen. The power elite have stigmatized people in low and middle income states as incapable of maintaining complicated regimes of medications. The power elite maintained a neocolonialist attitude, which placed an emphasis on their economic stature as a position to dictate to others on what is best for them.

The power elite believed that poverty stricken populations were incapable of comprehending and maintaining complicated medical regimens. The power elite (e.g., World Bank) maintained their dominant roles as experts in determining what was best for low and middle income states. Escalated costs of medications were another barrier that prevented low and middle income states from purchasing HIV medications. International agreements were made on Trade-related Aspects of Intellectual Property Rights (TRIPS) in 1995 (Cohen & Lybecker, 2005). TRIPS required states to acknowledge property

rights for all signatories, which provides international protection for patents (e.g., medications) and copyrights (Cohen & Lybecker, 2005). Brazil adopted and became compliant with TRIPS in 1996 (Cohen & Lybecker, 2005). The power elite once again used TRIPS to secure their power and determine how resources would be distributed globally.

Brazil's commitment to providing free access to medications for PLWHA required the Ministry of Health to determine the most cost effective delivery system. The Ministry of Health took a bold approach and produced HIV/AIDS medications locally (Bacon et al., 2005). Brazil's support for PLWHA human right to access medications prevailed and in 2001 the United Nations passed a resolution "…that makes access to medical drugs in cases of pandemics such as HIV/AIDS a basic human right" (Galvão 2005, p.1112). Shortly thereafter, the World Trade Organization "…allowed countries to apply for compulsory licensing in order to produce necessary medicines in cases of national public health emergencies" (Galvão 2005, p.1112). Brazil's initiative resulted in a 54% annual reduction of expense per patient (U.S. $2,637 savings) on HAART medications from 1997 to 2001 (Bacon et al., 2005).

Brazil's response to HIV/AIDS required pharmaceutical companies to renegotiate prices that were comparable for other low and middle income states. Brazil's victory over pharmaceutical companies shifted the negotiation process and provided more leverage for low and middle income states. Low and middle income states are now able to negotiate deep discounts from pharmaceutical companies or locally produce medications out of "national emergency" (Cohen & Lybecker, 2005). Brazil has changed

how HIV/AIDS is perceived in low and middle income states and shown that stronger initiatives can be taken to provide treatment to PLWHA.

Brazil's history of transitioning from a dictatorship to a democratic state has highly influenced the social movement response to HIV/AIDS. As de Ferranti and colleagues (2004) mentioned it is important to take into consideration the development of social structures and factors that reinforce inequality. The first phase of people affected by HIV/AIDS was a privileged class of highly educated professionals. Although they were marginalized due to their homosexuality, they still had access to resources to protect their interests. In addition, the social movement that resulted in the democratization of Brazil allowed HIV/AIDS activists to establish coalitions with fellow activists. Citizenship and solidarity resulted in a movement towards human rights.

The HIV/AIDS movement in Brazil reinforces researchers (de Ferranti et al., 2004) claims that effective policy changes must come from within the social structures as well as from the outside. Activists initially encountered resistance from the government, but their persistence has resulted in one of the most effective responses to the HIV/AIDS epidemic. NGOs assisted the government in developing a national response to HIV/AIDS. As the government developed an epidemiological system to monitor HIV/AIDS, NGOs were out in the community providing prevention services. Activists utilized the legal system to hold the state accountable to provide healthcare for PLWHA. Brazil saw that the state was in a public health emergency and the lives of PLWHA were in danger due to the medical patents imposed by TRIPS. Pharmaceutical companies were unwilling to provide affordable medications to Brazil, which resulted in higher AIDS mortality rates for the sake of profit. Brazil was able to implement the necessary

infrastructure to develop the same medications at a fraction of the cost. Brazil's response challenged the pharmaceutical companies to negotiate the cost of medications or lose the business from other low and middle income states (e.g., India) who could produce affordable medications for their citizens. The decision to prevent a public state of emergency at the expense of profit for pharmaceutical companies resulted in a fair price exchange determined by the state's economy.

Summary

The HIV/AIDS epidemic affecting poverty stricken communities will require Brazil to account for the disparities people face due to inequality. AIDS incidence rates have stabilized for Brazilian MSM, but have escalated among historically oppressed heterosexuals (e.g., black Brazilians). Inequality has increased vulnerability to HIV transmission among historically oppressed populations, which has evolved HIV/AIDS from a concentrated epidemic (e.g., MSM, IDU) to a generalized epidemic in some states. Initially HIV/AIDS had a disproportionately large incidence rate among white gay men, but the pandemic is now spreading to poverty stricken populations. The limited research available on vulnerable populations in Brazil indicates that: unemployment and lower education is associated with greater HIV prevalence rates (Bacon et al., 2005); poor PLWHA are less likely to access healthcare services (Biehl, 2004); marginalized youth are likely to have their first sexual encounter at age 13 (Peres et al., 2002); limited access to resources causes female Indians to have sex in exchange for resources (Bacon et al., 2005); and CSWs expressed that police violence outweighed concerns for HIV/AIDS (Hinchberger, 2005). In addition, Brazil's epidemiological data does not show information to demonstrate how inequality can increase one's susceptibility to

HIV/AIDS. Brazil is not unique in its predicament; internationally the HIV/AIDS pandemic has disproportionately affected females, people of color, and poverty-stricken communities.

The U.S. is also encountering the same obstacles as Brazil. Historically oppressed and highly marginalized populations become more susceptible to HIV and are the least likely to obtain quality healthcare. The American power elite have been successful in framing human rights as an issue for low and middle income states, but inequality is pervasive in high income states as well. Brazil's human rights approach towards HIV/AIDS provides a foundation for American HIV/AIDS activists to collaborate with other interest groups (e.g., cancer, leukemia, Alzheimer's) in pressuring the power elite for greater access to quality healthcare and cheaper medications, which also presents a model for providing affordable medications. The U.S. has access to greater resources and should set the standard in reducing inequality and ensuring appropriate healthcare for society.

Brazil reinforces solidarity and maintains that racism does not exist, but inequality paints a different picture. For example Brazilians are less likely to identify as black. Latinos in the U.S. are similar to Brazilians in racial identification and are more likely to identify as white disregarding their indigenous and/or African roots. The theoretical chapter will provide greater insight into Latino white privilege and the implications of social stratification within a historically oppressed population (i.e., Latinos). Americans will need to restructure their segmented advocacy approach and unite towards a greater human rights initiative as Brazil in order to effectively address the needs of historically oppressed and highly marginalized populations.

6. Literature Review

6.1. *HIV/AIDS among Latinos*

The Latino population is the largest community of color in the U.S. In 2009, the states with the greatest number of Latinos were California (14.1 million), Texas (9.9 million), Florida (3.7 million), New York (3.3 million), Arizona (2.1 million), and Illinois (1.7 million) (Kaiser, 2010). The country of origin among Latinos varies throughout the U.S. According to the U.S. Census (2010) for 2009, Mexicans are the primary Latino population in Arizona (92%), Texas (87%), California (84%), and Illinois (80%). In 2009, Puerto Ricans were the primary Latino population in New York (34%) and Cubans in Florida (29%) (U.S. Census, 2010). The "Other Hispanic or Latino" U.S. Census (2010) category was greatest in New York (51%) and Florida (36%), which includes Dominicans and Latinos from Central and South America (e.g. Colombia, Costa Rica, Ecuador, Peru).

Country of origin provides insight into the HIV/AIDS epidemic among Latinos in the U.S. Among Puerto Rican males with an AIDS diagnoses, the greatest exposure categories for HIV was IDU at 43.6% and MSM at 32.2% (CDC, 2010). The CDC (2010) reported MSM as the primary exposure category for Latino males with an AIDS diagnoses by place of birth in 2008 for 76.7% of South Americans, 66.4% of Central Americans, 66.1% of Mexicans, and 65% of Cubans. Latinos (48%) were also more likely to seek testing for HIV later in their illness (Kaiser, 2003).

Among NYC residents that are foreign-born, the greatest number of newly diagnosed HIV infections from 2001 to 2006 was among Dominicans (584), Jamaicans (469), and Mexicans (413) (NYC DOHMH, 2008). People from the Caribbean and West

Indies, which include the Dominican Republic and Jamaica, had the greatest number (2,256) of newly diagnosed HIV infections in NYC (NYC DOHMH, 2008). People from Central and South America, which include Mexico, had the second highest number (1,742) of newly diagnosed HIV infections in NYC (NYC DOHMH, 2008). Country of origin is an important factor to consider when discussing issues related to Latinos.

Glasman and colleagues (2010) recruited 302 men of Mexican descent in the Midwest to complete a self-administered questionnaire exploring cultural factors associated with HIV testing. The study (Glasman et al., 2010) found that uninsured Spanish speaking foreign born recent immigrants were more likely to take an HIV test than English speaking men of Mexican descent. Glasman et al. (2010) indicated that men who used condoms with sexual partners were more likely to take an HIV test. Protecting the family and community were strong motivating factors for HIV testing among men (Glasman et al., 2010). Men that associated HIV testing with stigma and fatalism were less likely to get tested for HIV (Glasman et al., 2010). Greater exposure to disease prevention services resulted in stronger intentions to get an HIV test (Glasman et al., 2010). The research study indicated that prevention programs that emphasize positive outcomes associated with HIV testing and encouraged people in the community to discuss their experiences completing an HIV test at-risk groups. Greater information also needs to address stigmas associated with HIV and medical advancements for treating HIV to promote HIV testing for harder to reach populations.

Alvarez and colleagues (2010) conducted a research study exploring predictors of condom use among 157 (78 males and 79 females) Mexican adolescents ages 17 though 21. A randomized control trial was conducted for a sexual risk reduction intervention

¡Cuidate! Promueve tu Salud in four high schools in Monterrey, Mexico (Alvarez et al., 2010). Pre and post-test questionnaires were administered at 3, 6, 12, and 48 month follow-ups to determine the effectiveness of the intervention (Alvarez et al., 2010). The study found that positive attitudes towards condoms, greater confidence that they could use condoms correctly, and greater confidence to encourage their partner to use a condom were significant predictors for condom use among adolescents (Alvarez et al., 2010). The majority of the sample reported condom use at sexual debut, but consistent condom use was not maintained (Alvarez et al., 2010). Alvarez and colleagues (2010) indicate that factors associated with the relationship with a partner such as status (e.g., steady relationship) and length of relationship can influence comfort in addressing condom use. The study indicates that perceptions of condoms and negotiating skills are key factors to consider for programs addressing HIV/AIDS among youth.

Beaulaurier and colleagues (2009) found that AIDS cases are rapidly growing among older Latina women, the least studied population regarding HIV/AIDS. Factors associated with old age (e.g., menopause, weaker immune system, chronic health conditions) increased susceptibility to HIV transmission among elderly Latina women (Beaulaurier et al., 2009). Beaulaurier and colleagues (2009) indicate that professionals working with elderly Latina women should provide HIV/AIDS education and prevention to address concerns of this highly overlooked population at risk for HIV transmission.

Latinos were three times more likely than whites to be diagnosed with HIV in 2008 (CDC, 2010). HIV transmission among MSM continues to increase, accounting for 54.4% of HIV infections in 2008 (CDC, 2010). The Kaiser Foundation (2010) found that New York (74,652), California (67,292), and Florida (48,645) have the highest number of

people with an AIDS diagnosis. New York (23,761), California (20,390), and Florida (9,038) were the top states for Latinos with an AIDS diagnosis (Kaiser, 2010). Illinois ranked number eight for people with an AIDS diagnosis (17,108) and number six for Latinos with an AIDS diagnosis (Kaiser, 2010). California and Illinois are not included in the 37 states with name-based HIV reporting, which account for a significant proportion of AIDS diagnoses among Latinos in the U.S. The CDC data on the HIV/AIDS epidemic does not distinguish Latino populations by ethnicity at the state level, which hinders efforts in understanding and addressing the epidemic through a cultural or ethnic lens.

6.2. *Race, Ethnicity, & Culture*

General racial epidemiological categories are useful to gain an understanding of how various populations are affected by an epidemic. The limitation of homogenizing populations is that it reduces insight into how an epidemic may impact various populations within a racial category. The HIV/AIDS epidemic, for example, demonstrates how disregard for the ethnic diversity of a racial group limits research initiatives in developing effective interventions for historically oppressed and highly marginalized populations. General racial epidemiological categories make historically oppressed and highly marginalized populations invisible, which reinforces their susceptibility to greater disparities. Generalized racial categories can also provide misleading information by focusing on highly accessible and/or privileged populations, leading to inadequate preparation of professionals to provide culturally competent services. “Experts” capitalizing on the despair of historically oppressed and highly

marginalized populations may reinforce stigmas in the training and development of professionals.

Williams and Collins (1995) report that racial groups such as black, white, and American Indian are social constructs created by the government to categorize people. Hispanic is regarded as an "ethnic" category, due to the Hispanic Diaspora and people identifying as black, Indian, or white and not Hispanic. Colonization of the Americas has resulted in a hybrid of races. Hayes-Bautista (1980) indicates that the term "Hispanic" reinforces racist stereotypes and means of "Spanish Origin." Racial and ethnic categories reinforce social status and access to resources, which is perpetuated in the U.S. as well as in Latin America. Hayes-Bautista (1980) emphasized that reference to a Hispanic as Spanish provided an increased level of social status since people from Spain are categorized as white, civilized, and of European descent; unlike Mexicans who are perceived as Indian, dark, and uncivilized. Mexico developed an elaborate ethnic classification system during the colonization period, which is categorized into three large groups such as Indian, *mestizo* (Indian and Spanish descent), and Spanish (Hayes-Buatista, 1980). Latino has been a term utilized from people of Latin America to claim their independence from Spain, acknowledge their indigenous roots, and avoid reinforcing oppressive structures. "Hispanics" are identified as Latinos in this study and as a racial group due to the homogenization of a population composed of heterogeneous ethnic groups (e.g., Mexican, Cuban, Puerto Rican, Dominican).

Phinney (2002) indicates that ethnic identity is a composition of various factors that are not stagnant, but dependent on an individual's understanding of the self in regards to "…culture, phenotype, religion, language, kinship, or place of origin."

Sexuality as an ethnic identity will be discussed in the following section. The definition of ethnic identity sheds light on the complex journey that one may go through and how it affects one's psychosocial self.

Schiller (1992) highlights how the battle against the HIV/AIDS epidemic has impeded prevention efforts through the utilization of "neutral epidemiological categories" of risk groups that fail to address oppression among people of color and marginalized populations. Researchers using terms such as "Hispanic" or "Latino" without regard for specific ethnic identity homogenizes the population and omits the cultural nuances that define specific groups.

Rinderle (2005) writes about the Mexican Diaspora in the U.S. and sheds light on the significance of ethnic identity with people of Mexican descent. For example, Mexicano comes from the Náhuatl indigenous dialect that refers to a group of Indians who migrated from Aztlán to Central Mexico (Rinderle, 2005). People from Mexico that immigrate into the U.S. usually identify with their country of origin (Rinderle, 2005). A Mexican-American identity acknowledges ancestry of Mexican descent and birth in the US, but assimilation into American culture may override Mexican beliefs and values. A Chicano identity acknowledges the richness of Mexican culture and takes a political position in the U.S. to advocate for the rights of "*la raza*" (the Mexican race). Rinderle (2005) has identified the most significant Mexican ethnic groups in the U.S. However, people from Mexico represent Indian civilizations that speak over 50 indigenous dialects.

The Kaiser Foundation (2004) has noted that country of origin is an important identity factor for Latinos in New York (66%), New Jersey (62%), Florida (62%), California (55%), and Texas (43%). Phinney (2002) shows how ethnic identity

influences an individual's perceptions and behaviors. Therefore, ethnic identity becomes an important factor to take into consideration in HIV/AIDS interventions to effectively target Latino populations. Labels such as "Latino" or "Hispanic" do not reflect the target population; they subjugate members and reinforce oppressive structures. However, for the purpose of this dissertation, the term Latino will be utilized understanding that it encompasses the implications of subjugation and reinforcement of oppressive structures, but with a coherent discourse emerges as more appropriate and less egregious than the term Hispanic.

Ethnic identity has a significant influence on how HIV interventions should be designed for historically oppressed populations. Power elite theory indicates that there is a hierarchy of power, which reinforces social stratification within as well as outside historically oppressed populations. A greater emphasis needs to be placed on the heterogeneity of the target population (e.g., Latino MSM) and greater initiatives should be reinforced for populations at greater risk of HIV transmission. The Latino MSM population has an intricate network that reinforces social stratification based on white privilege, socioeconomic status, educational attainment, acculturation, and gender norms (e.g., masculine men that people assume are straight). Social providers that emphasize a Latino target population should be required to provide the same services in Spanish as well as English. Request for HIV intervention proposals should require providers to present a strategy for accessing populations at greater risk of HIV transmission. HIV interventions designed to address the needs of Chicanos would need to take a political focus while interventions addressing the needs of Mexican immigrants should shift their initiatives towards access to healthcare, housing, employment, and food. Providers

should be able to articulate the heterogeneity of the Latino population in order to effectively address the needs of Latinos. Developing a greater understanding of sociocultural factors such as acculturation, gender, ethnicity, and sexuality allow professionals to develop HIV interventions that are empowering and more effective in addressing the needs of the community.

6.3. *Latinos & Immigration*

Immigration is a controversial topic due to the current state of the economy. The dominant group has blamed immigrants for depleting resources in the U.S. "The Federation for American Immigration Reform (FAIR) is a national, nonprofit, public-interest, membership organization of concerned citizens who share a common belief that our nation's immigration policies must be reformed to serve the national interest" (FAIR, 2010). FAIR has taken an aggressive stand in promoting xenophobic initiatives in the community as well as public policy. Governor Jan Brewer has taken the latest initiative by enacting Senate Bill 1070 for the state of Arizona, which allows law enforcement to identify, prosecute, and deport illegal aliens. Militias have also risen in response to xenophobic attitudes and the presented need for U.S. citizens to take action in protecting their land from unwanted intruders. The Texas Border Volunteers are a prime example of such militia groups whose mission is to assist law enforcement in protecting the border from illegal immigrants. The following statistics will provide a greater understanding of immigration demographics and implications for the HIV/AIDS epidemic in the U.S.

The US Census Bureau (2005) estimated for 2005 that there were approximately 42 million Latinos with Mexicans (64.0%) being the largest nationality followed by Puerto Ricans (9.0%), Cubans (3.5%), Salvadorans (3.0%), and Dominicans (2.7%). The

primary age cohort among Latinos is 15 to 44 years old (US Census Bureau, 2003). Despite Latinos being the largest population of color, they are the least likely (58.7%) to be high school graduates or have some college education proceeded by American Indians and Alaska Natives (75.9%), and Blacks or African Americans (78.6%) (US Census Bureau, 2003).

Stepick and Grenier (1993) indicate that Cubans are the wealthiest Latino population thanks to social welfare initiatives in the 1970s and 1980s for Cuban refugees, which allowed them to establish an economic foundation in Florida. Puerto Ricans fall in the other extreme and are more likely to have families (22.8%) and individuals (24.8%) below the poverty level. However, the poverty rate for Mexicans (20.9% for families and 22.8% for individuals) is close to that of Puerto Ricans (US Census Bureau, 2003). The US Census Bureau (2003) reports that Cubans (43%) are the most likely to be out of the labor force despite being the wealthiest group of Latinos, followed by Puerto Ricans (37.8%) and Mexicans (30.8%). Brown and Yu (2002) emphasized that Latinos in general are the least likely to be offered comprehensive employment-based health insurance regardless of educational, professional, and economic status when compared with whites. Mexicans in particular are less likely than any other Latino group to have access to health insurance at work due to their undocumented status (Brown & Yu, 2002).

The top three states with foreign born residents are California (27.2%), New York (21.4%), and New Jersey (19.5%) (US Census Bureau, 2005). Hoefer, Rytina, and Campbell (2008) reported that there are an estimated 11.8 million undocumented immigrants residing in the U.S. California (2.8 million) has the largest number of undocumented immigrants followed by Texas (1.7 million), Florida (960,000), New York

(640,000), and Illinois (560,000) for 2007 (Hoefer, Rytina, & Campbell, 2008). Although undocumented Mexicans are the largest Latino immigrant population in the U.S., the greatest increase of undocumented immigrants from 2000 to 2007 was among immigrants from India and Brazil (Hoefer, Rytina, & Campbell, 2008).

White Americans have a strong bias against immigrants and prefer greater restrictions to prevent foreigners from immigrating into the U.S. due to fear of increased crime rates, cost of education, demand of social services, and lower rates of property value (Cornelius, 2002). Greater restrictions on immigration policies have taken place since the 9/11 terrorist attacks in the US. A survey in 2006 reported that Latinos believed that there is an increase in discrimination due to the immigration bill passed in December 2005 to criminally prosecute undocumented immigrants (Suro & Escobar, 2006). The restrictions on immigration by the government caused Latino communities, foreign born and native, to mobilize and protest anti-immigration policies (Suro & Escobar, 2006).

Nationality, employment status, and immigration status among Latinos strongly influences access to healthcare, which may increase susceptibility to HIV infection. The odds of not receiving healthcare among Latinos overall seems to be greater than any other racial group. Greater insight into the complex environment Latino immigrants experience will assist in improving healthcare and reducing HIV prevalence rates among a marginalized population.

6.4. *Acculturation*

The following section on acculturation provides greater insight into the Latino diaspora. Acculturation is a significant factor to consider among Latinos in order to gain insight into how social stratification occurs within the population and how it influences

susceptibility to HIV/AIDS. Power elite theory is also discussed to explore further the implication of power and status within a historically oppressed population. For example, Latinos that have high levels of acculturation are more likely to have greater access to resources when compared with Latinos that have low levels of acculturation.

Marin and Marin (1990) interviewed 460 Latinos in San Francisco via the telephone. More than half (53%) of the sample identified as Central American followed by Mexican American (29.7%), Puerto Rican (5.1%), and other Latino origin (Marin & Marin, 1990). The majority (73%) of the sample were considered to have low acculturation levels (Marin & Marin, 1990). The study found that respondents with lower levels of acculturation also had lower levels of HIV/AIDS knowledge.

Mikawa and colleagues (1992) explored the influence culture has on HIV/AIDS prevention among 192 Latinos in Nevada via a self-reported questionnaire. Participants were primarily from Mexico (61.1%) followed by the United States (17.9%), South America (8.4%), Central America (5.3%), and Cuba and Puerto Rico (1.1%) (Mikawa, et al. 1992). They (Mikawa, et al. 1992) found that participants with lower levels of acculturation had greater levels of "*machismo*," less fear of AIDS, and a greater belief in fate. Also, religion did not have a significant influence on condom use.

Miller, Guarnaccia, and Fasina (2002) also conducted a quantitative research study over the phone on the influence of AIDS knowledge and culture among 121 Latinos (70.2% foreign born) living in New Jersey. Participants identified as Puerto Rican (30.6%), South American (26.4%), Cuban (12.4%), Dominican (9.9%), Mexican (9.1%), and Central American (8.3%) (Miller, Guarnaccia, & Fasina, 2002). Miller, Guarnaccia, and Fasina (2002) found that participants with lower levels of educational

attainment and bilingual language exposure had less knowledge about AIDS. Spanish dominant speakers that were educated in their home country were less likely to be exposed to an English speaking environment, lived less than 10 years in the U.S., had less than a high school education and had lower levels of AIDS knowledge when compared to bilingual and English speaking groups (Miller, Guarnaccia, & Fasina, 2002).

Bianchi and colleagues (2004) conducted a study that explore how sociocultural factors influenced coping and health behavior among 140 HIV positive Latino gay men in New York (n=79) and Washington DC (n=61). The entire sample was foreign born from South America (n=57), Caribbean (n=35), Central America (n=29), and Mexico (n=19) (Bianchi, et al. 2004). Overall, 40% indicated that they came to the U.S. to improve their financial situation, but 36% indicated that they came to the U.S. to live as a homosexual and 26% indicated that they came to get HIV medications (Bianchi, et al. 2004). Latinos that were more acculturated had better coping strategies, which enabled them to take better care of their health (Bianchi, et al. 2004). Sociocultural indicators such as power inequality, social injustice, and oppression hindered an individual's ability to reinforce health-promoting behaviors (Bianchi, et al. 2004). The men experienced greater discrimination based on sexual orientation than on race, but did not have any significant outcomes related to health-promoting behaviors (Bianchi, et al. 2004).

A qualitative research conducted by Shedlin, Decena, and Oliver-Velez (2005) corroborated the findings on the implications that acculturation has on HIV/AIDS knowledge among immigrant populations. "The hispano (Hispanic), they agreed, was not aware of the prevalence of AIDS, the risk of infection, symptoms or consequences" (Shedlin, Decena, & Oliver-Velez 2005, p.35S). Established connections with an

immigrant's home country reinforced existing beliefs and behaviors (Shedlin, Decena, & Oliver-Velez, 2005). The study (Shedlin, Decena, & Oliver-Velez, 2005) indicated that factors such as mental health, gender norms, social behavior, sexual behavior, and substance use were affected by the initial stages of acculturation among immigrants.

Immigrants indicated that work was their primary concern due to their financial support of dependents in their home country or debt for being smuggled into the country (Shedlin, Decena, & Oliver-Velez, 2005). Preexisting health (e.g., malnutrition, anemia, diabetes, asthma) and mental health (e.g., depression, stress) conditions became secondary to meeting their basic needs (e.g., money, housing, food). The environment (i.e., urban, rural) influenced social and sexual behavior. Rural environments had greater negative implications for men due to limited areas to congregate and the reduced chance of meeting female partners (Shedlin, Decena, & Oliver-Velez, 2005). Men in rural areas were more likely to have sexual encounters with sex workers due to the lack of potential female partners (Shedlin, Decena, & Oliver-Velez, 2005). Although most immigrant men denied MSM behavior, but informants indicated that sex between men did take place in all male households (Shedlin, Decena, & Oliver-Velez, 2005). Older immigrant men were more likely to binge drink and younger immigrant men were more likely to use drugs (e.g., cocaine, marijuana) as an escape from their dire predicament (Shedlin, Decena, & Oliver-Velez, 2005).

6.5. *Machismo*

Gender must also be taken into consideration when discussing sexuality among MSM, but a special emphasis needs to be placed on *machismo*. The term *machismo* has been facetiously used by "experts" in explaining social problems among Latino males.

Latino males historically have been inappropriately stigmatized as oppressive males and the term *machismo* reinforces their subjugation as a cultural anomaly. *Machismo* is used loosely in Spanish to emphasize masculine gender traits among males, but it can have positive as well as negative connotations. The consequences of not accurately conceptualizing *machismo* have reinforced oppressive structures in stigmatizing Latino males and prevented the development of effective interventions addressing social problems among Latinos. The following section will attempt to discuss *machismo* and shed insight on the implications it can have in conducting research with Latinos and the development of culturally appropriate interventions.

The term *machismo* has been use to characterize Latino men as sexual predators, promiscuous, oppressors, substance users, physical abusers, controlling and homophobic (Bull, 1998; Singer et al., 1990; Sternberg, 2000; Wood & Price, 1997). However, among Latino men, *machismo* also has positive traits such as self-sufficiency, hard work, honor, family provider, and protector (Bowdy, 1997; Sternberg, 2000). Researchers have failed to recognize that *machismo* is understood within the culture as having a range of masculine characteristics. It not only encompasses maladaptive social behavior patterns among Latino men, but represents positive behaviors as well. Utilizing the term *machismo* in studies addressing HIV/AIDS stigmatizes Latino men and disregards the psychosocial context of their lives. *Machismo* exists in every race and ethnicity, but when it applies to white men an emphasis is placed on negative behavior such as domestic violence and substance abuse and not contextualized as a cultural anomaly.

Religion has a strong influence on masculinity among Latinos, which reinforces *machismo* and homophobia in the community (Bull, 1998; Carrillo, 1999; Sternberg,

2000; Willliams et al., 2004). Wood and Price (1997) indicate that *machismo* is rooted in how "God was perceived in the Hispanic culture" and elaborates on the influence that colonialism has among Latino men. God was viewed as a powerful male and saying, "I am your father" was a way to subjugate someone (Wood & Price, 1997). The Spanish imposed their power and authority on Indian civilizations by pillaging villages and sexually assaulting women at free will. Therefore, in order to gain power during the colonization of the Americas, which still persists today, men's status became dependent on their ability to subjugate others through sexual relations, which is characterized as *"el mas chingon"* (the biggest f--ker). A straight identified Mexican male who takes the *"activo"* (active/top) role and penetrates the *"pasivo"* (passive/bottom) partner does so as a proclamation of power and domination.

As the HIV/AIDS pandemic grows, researchers are challenged to develop a greater understanding on how gender roles reinforce behavior. Gender roles provide scripts for Latino MSM; the *activo* partner acts in the masculine role and the *pasivo* acts in the feminine role (Wood & Price, 1997). Mexican males are aware during their childhood that any indication of homosexuality threatens one's masculinity (Singer et al., 1990). Researchers (Bowdy, 1997; Singer et al., 1990) have incorrectly specified that in Mexican culture one is either active or passive, there is no in between. Cáceres and Rosasco (1999) found among Peruvian men that *activo* and *pasivo* roles exist, but there are also *"modernos"* (a partner that takes the active and passive role) among MSM. Mikawa and colleagues (1992) indicate that HIV interventions should focus on the Latino male's role as a protector to encourage men to use condoms.

6.6. *Sexual Identity*

Identity is an important factor to consider when discussing social problems especially when working with historically oppressed and highly marginalized populations. Social stratification influences one's ability to identify with a particular group. Identity, which is fluid, is dependent on the environment and dominant social group. One must take into consideration how identity influences power and status within a particular social setting. One's ability to pass for various identities (e.g., white, straight, educated, HIV negative) is influenced by age and other factors in various settings. Among historically oppressed MSM, the most influential factors associated with power have been race, gender, sexuality, education, and HIV status. Power Elite Theory provides an understanding of how a complex structure of power can influence one's identity within a social structure. The same rules apply to how one obtains power and status, but you also have pioneers that confront and challenge norms and make their presence known despite the stigmas. Overall, this complex navigation of one's identity within a complex system influences one's ability to access resources, which may exacerbate the HIV/AIDS epidemic within historically oppressed populations.

Ethnicity also influences one's sexual identity and perceived role in social settings. Cáceres and Rosasco (1999) found that among Peruvian MSM, sexual identity was associated with homosexual stigma. The men expressed that "passing" as straight provided a sense of economic security, safety, and social status. Roque-Ramirez (2003) identifies *"sexiles"* as people who need to leave their community or country due to their sexual orientation. Sexual identity is a hybrid of psychological, social, and behavioral traits of the individual (Carrillo, 1999). Unlike in American culture, a heterosexual

Latino male does not have to be attracted only to women and is able to have sexual encounters with men. The active (insertive partner) male gains the highest status among Latino MSM (Carrillo, 1999; Cáceres & Rosasco, 1999). If an MSM is identified as a homosexual the assumption is made that he is passive, effeminate, and the receiver. Researchers (Bowdy, 1997; Singer et al., 1990) have found that effeminate men are stigmatized as *"putos"* (men that get f---ed) and/or *"jotos"* (fags). *Putos* or *jotos* are objectified and perceived as sexual outlets. *"Mayates"* (straight identified MSM) find it acceptable to have sex with *jotos* and suppress their awareness of having sex with a male (Carrillo, 1999). *Mayates* reinforce their psycho-cultural scripts in proclaiming their status as *el mas chingon*.

Sexual identity as gay, straight, or bisexual among Latino men affects their understanding of psycho-cultural scripts when relating to other men. For example, gay identified Latino men were more likely to want a loving committed relationship with another male (Cáceres & Rosasco, 1999). Straight identified Latino MSM indicated that homophobic attitudes in the community discouraged intimacy between two men and reinforced the attitude that gay men were merely a source of sexual gratification (Williams et al., 2004). Marsiglia (1998) found that straight identified Latino MSM disassociate their sexual identity from their sexual behavior, which allows them to maintain their role as "machos." Homophobic attitudes and lack of support from the community prevent emotional intimacy between men, which may cause them to suppress their homosexual desires and participate in anonymous sexual encounters with other males as an outlet (Marsiglia, 1998). Latino MSM indicated that their first sexual encounters made them feel perplexed, guilty, and fearful; the sex felt good, but society

looked down on homosexuality (Cáceres & Rosasco, 1999). Latino MSM that who are able to pass as straight did not jeopardize their social network, employment status, family support, or safety (Cáceres & Rosasco, 1999).

As Dubé and Savin-Williams (1999) indicate, people of color experience dual identity based on race and sexuality. A person of color would develop internal conflict based on cultural disapproval of homosexuality. Marsiglia (1998) indicates that some Latinos perceive the "gay community" as a white middle-class culture, which reinforces oppressive structures that exclude people of color. Their culture's condemnation of homosexuality and the discrimination from the gay community for being a person of color isolate gay, lesbian, and bisexual Latinos in the larger gay community make it difficult to establish an identity. Roque-Ramirez (2003) sheds insight on Chicano *sexiles* and describes how the isolation from the gay and Chicano communities led to creating a community for gay and lesbian Chicanos. Establishing a gay Chicano community allowed members to become empowered and integrate with the Latino communities to strengthen opportunities for *la raza* (Roque-Ramirez, 2003). Ethnicity prevailed over sexuality and their support of other Latinos groups liberation struggles gained them respect and acceptance with Latinos. Race, ethnicity, and culture were critical factors that reinforced social stratification within the gay community, which resulted in gay Latinos forming their own social support networks within a marginalized predominantly gay white community. Race, ethnicity, and culture were found to influence one's social identity, but age was found to influence one's self-identity.

Dubé and Savin-Williams (1999) identified the following milestones for sexual identity based on age: awareness of homosexual attraction (8-11); homosexual sexual

encounter (12-15); identity as gay or bisexual (15-18); disclosure to others such as sibling, parent, heterosexual friend, and homosexual friend (17-19); and development of homosexual romantic relationships, which was defined as being in a committed relationship (18-20). Latino male sexual identity development was consistent with these milestones: the average age for homosexual awareness was 8; the average age for sex with a male and identity as a gay or bisexual was 15; the average age for disclosure was 16; and the average age for homosexual romantic relationship was 18 (Dubé & Savin-Williams, 1999). Latinos reached the developmental stage at a youngster age for homosexual awareness, identity as gay or bisexual, and disclosure (Dubé and Savin-Williams, 1999). Greater understanding between one's social and self-identity provide practitioners with essential insight on how to enhance HIV interventions based on age as well as cultural nuances. The sexual identity milestones indicated that youth start to think about homosexuality at about eight years of age and the average age of a homosexual encounter was about fifteen years of age. Practitioners can argue based on the findings that sexual educational courses in high-school play a critical role in educating adolescents on how to reduce their risk of exposure to sexually transmitted diseases. Greater research is needed to explore the influence social and self-identity has on risk-related behaviors among various Latino ethnic populations as well as other racial groups to develop interventions to better serve the community.

6.7. *Faith-based Initiatives & HIV/AIDS*

MSM of color have had significant struggles in coming to terms with their sexuality and HIV status. One obstacle that MSM of color encountered was their childhood religious congregation. MSM of color expressed that they were raised with

strong religious beliefs that emphasized homosexuality as a sinful abominable act. They would felt guilty for having homosexual desires and struggled with coming to terms with their sexuality. Religious rhetoric would reinforce discrimination against homosexuals, which caused some MSM of color to leave their childhood religious congregation as adults. HIV infection introduced a renewed yearning for spirituality and/or to join a religious congregation, but MSM of color indicated that the conflict between their sexuality and religious beliefs caused them to seek nondenominational religious institutions that embraced their sexuality and/or HIV status.

A significant gap in the literature is found in distinguishing religiosity from spirituality and exploring the impact that religious institutions have on the HIV epidemic among MSM of color. The term faith-based is utilized to include religious as well as spiritual research that explores the role of HIV/AIDS among Latinos and people of color. The literature also places an emphasis on individual religious and spiritual experiences, but neglects religious institutions as the source of reinforcing religious rhetoric and the effect on homosexuals and PLWHA.

The Pew Research Center (2007) indicated that the majority of Latinos in the U.S. specified their religion as Catholic (68%) followed by Protestant (20%), no religious affiliation (8%), and other religious affiliation (4%). Religious institutions can have a profound impact on addressing the HIV/AIDS epidemic, but special consideration must be taken among marginalized groups such as Latino MSM. Overall, 58% of Americans report that homosexuality should be accepted in society (Pew Research Center, 2011). Participants that were unaffiliated with a religious denomination (79%), white Catholics (66%), and white mainline Protestants (65%) were also more likely to indicate that

homosexuality should be accepted whereas, 69% of white Evangelical Protestants indicated that society should discourage homosexuality (Pew Research Center, 2011). The Pew Research Center (2011) reported that Latinos rated the highest (64%) in support of homosexuality when compared with white (58%) and African Americans (49%).

Gaydos and colleagues (2010) conducted a literature review on religion and reproductive health, which indicated that in the past eight years there was an increase in scholarly publications addressing religion and reproductive health. Religion has been historically overlooked as a significant component of the healthcare debate, but religious measures have evolved recently to demonstrate the influence religiosity has with physical and mental health outcomes (Gaydos et al., 2010). An emphasis on culturally appropriate healthcare services for the community has also increased awareness of the implications race, ethnicity, and religion have on health seeking behaviors and well-being in the community. The literature has also demonstrated an interdisciplinary approach of professionals collaborating with various academic disciplines in ameliorating healthcare disparities among disenfranchised populations (Gaydos et al., 2010). Religious beliefs and values influence one's perception of reproductive health. Religious organizations have an established network that enables religious leaders to influence community norms (Gaydos et al., 2010). Historically, religious organizations have been pillars of support for their members, but they continue to struggle with addressing the needs of the community when issues conflict with religious beliefs and values (Gaydos et al., 2010).

Francis and Liverpool (2009) conducted a review of empirical research related to faith-based initiatives addressing HIV/AIDS in the black community and found that many churches struggled with addressing issues related to sex and drug use in the context

of HIV/AIDS. The following strategies were identified by the researchers (Francis & Liverpool, 2009) as successful attempts across programs: 1) integrating the FBO and target population with the development, implementation, and evaluation of HIV programs; 2) partnering with religious liaisons that are committed to the cause as active participants in addressing HIV in the community; 3) contextualizing initiatives through a spiritual and compassionate approach in addressing HIV/AIDS in the community; 4) developing culturally appropriate programs that integrate beliefs and values from the community; and 5) creating a sense of ownership among the target population. Comprehensive sexual education was also seen as an essential component that provided age appropriate information for youth to build their skill-set in making decisions related to relationships, assertiveness, and peer pressure (Francis & Liverpool, 2009). Trainings were provided for religious liaisons to discuss sensitive issues that conflicted with religious beliefs, or referrals were made to reputable professionals to maintain the mission of the religious group (Francis & Liverpool, 2009). Overall, public health professionals must be willing to compromise in order to work effectively with religious communities and respect the mission of a religious organization.

Harris (2010) indicates that churches reflect the cultural values of the community, which resulted in many black church leaders in New York not addressing HIV/AIDS at the start of the epidemic because the media emphasized that it was a disease that impacted gay white men. The religious community struggled with addressing highly taboo subjects (e.g., injection drug use, homosexuality, promiscuity) that placed people at greater risk of HIV transmission and they did not want to acknowledge that “deviants” existed within their congregation (Harris, 2010). The black church has historically

provided a safe haven for blacks from racial discrimination and oppression (Harris, 2010). Some gay black men chose to detach themselves from their sexuality in church in order to remain part of their congregation (Harris, 2010). Congregations are aware of gay and lesbian religious members within their congregation, but religious leaders reinforce heterosexist religious rhetoric that promotes homophobia and hinders progress towards addressing HIV/AIDS in the community (Harris, 2010). Prayer has been the beacon of light for HIV/AIDS activists to get their foot in the door and emphasize how Jesus cared for the sick (Harris, 2010).

Latinos encounter the same obstacles as the black community due to racism, homophobia, and HIV/AIDS stigma in the community. Religious leaders in Latino as well as black churches struggle with addressing taboo subjects such as homosexuality, premarital sex, and injection drug use. The Catholic Church in particular has historically condemned homosexuality and the use of contraceptives. The media has also played a significant role by emphasizing that HIV/AIDS primarily impacted gay white men at the start of the epidemic, which has transitioned to IDUs, and currently the black community. Latino religious leaders might not perceive HIV as a threat to the Latino community if members of their congregation are not associated with "high-risk" populations (i.e., gay white men, IDUs, black community).

The church also provides a significant resource for historically oppressed populations to overcome obstacles. Among Latino immigrants the church provides access to an established community, which can help immigrants acclimate to a new environment. The religious community provides an informal support network for Latinos to support one another and overcome obstacles reinforced by the power elite such as

unemployment, access to healthcare, and/or housing. The church can also play an instrumental role in providing legal support for undocumented immigrants facing issues such as deportation. A significant strength as well as a limitation is that churches reflect cultural values in the community and they may not address HIV/AIDS until members from their congregation are being affected by the epidemic. Christianity overall has struggled with using scriptures as a source for the religious community to support highly marginalized populations such as PLWHA and MSM in the community.

Cotton and colleagues (2006) conducted a literature review exploring the influence distal and proximal religious domains had on health outcomes among adolescents (ages 12-20). Distal domains are external factors (e.g., service attendance, frequency of prayer, self-rated religiousness) related to religious groups. Proximal domains are protective factors (e.g., meaning and peace, religious coping, church support) that are internalized and reinforced by religious beliefs and values (Cotton, et al., 2006). Cotton and colleagues (2006) found that adolescents with higher levels in the proximal domain were less likely to experience substance use (marijuana and hard drug use), sexual activity, depression, and suicide. Higher scores in the distal domain were associated with lower alcohol use (no other drugs) and social support was a key mediator for lowering levels of depression (Cotton et al., 2006).

Dew and colleagues (2008) also found in a literature review that religion/spirituality was a protective factor among adolescents for substance use, delinquency, depression, and suicidality. Adolescents who scored higher in religious attendance, importance, beliefs, and denomination were demonstrated to have better mental health outcomes (Dew et al., 2008). Most importantly, researchers acknowledge

how the literature conceptualizes religion and the need to further explore the variables related to religion and its relationship to mental health (Dew et al., 2008), and sexual intercourse (Burdette & Hill, 2009).

Rostosky and colleagues (2008) found that religiosity among sexual minorities declined significantly from adolescence to young adulthood when compared with heterosexual youth. Religiosity was not a protective factor for sexual minorities as it was for heterosexual youth (Rostosky et al., 2008). Historically oppressed (e.g., Latinos, blacks) and highly marginalized populations (e.g., homosexuals) deal with multiple stigmas based on racial discrimination, homosexuality, and HIV within as well as outside of their racial groups. Phenotypic features for Latinos and blacks resulted in racial discrimination, but sexuality and HIV status allowed disclosure among various social networks.

Bauermeister and colleagues (2007) explored sexual prejudice among 360 heterosexual undergraduate students (57.5% of the sample was female) in Puerto Rico and found religiosity to be the strongest predictor of sexual prejudice. Participants that reported greater interactions with homosexuals were less likely to be prejudiced towards homosexuals (Bauermeister et al., 2007). Herek and Capitanio (1996) also found that heterosexual people that reported contact with two or more homosexuals had significantly lower negative attitudes towards homosexuals. Participants that reported an intimate relationship (i.e., close friend) had significantly lower negative attitudes towards homosexuals than people that reported a gay distant family member (Herek & Capitanio, 1996). Overall, the study focused on 93.9% (n = 505) of the sample that identified as heterosexual (Herek & Capitanio, 1996). A majority of the sample (81% white and

54.1% female) reported negative attitudes toward gay men and agreed that "sex between two men is just plain wrong" (Herek & Capitanio, 1996).

Gillum and Holt (2010) found that women who reported greater than weekly attendance of religious services had lower prevalence rates of sexual risk factors when compared with women who never attended religious services. Religious affiliation among men corresponded to increased sexual risk factors if they identified as fundamentalist, non-denominational Protestant, and other non-Christian denominations (Gillum & Holt, 2010). Women were also more likely to be involved in religious activities than men (Gillum & Holt, 2010). In addition, men who reported that religion is not important had lower prevalence of drug-related risk (Gillum & Holt, 2010).

Burdette and Hill (2009) measured religious involvement through *religious salience, private religiosity, and family religiosity*. Religious salience measured how important religious faith was in shaping one's daily life. Private religiosity measured how often one prayed or read religious scriptures. Family religiosity measured how often a family prayed together or talked about religious beliefs. Participants that had high levels of religious salience were more likely to delay adolescent sexual behavior (Burdette & Hill, 2009). Private religiosity delayed sexual touching and church attendance delayed sexual touching and sexual debut (Burdette & Hill, 2009). Family religiosity delayed sexual intercourse among white and black youth, but not among Latino youth (Burdette & Hill, 2009). Burdette and Hill (2009) also emphasized that if religiosity is enmeshed with cultural identity it can cause a de facto religious affiliation among youth, but it might not directly influence their behavior. The researchers (Burdette & Hill, 2009) further indicated that religious youth might be less likely to

partake in risky behavior based on their temperament, which could reinforce religious involvement.

Tatman (2004) emphasized how religious institutions attempt to control the sexual desires, beliefs, values and behaviors of the community. The Catholic Church perceives homosexuality as a "problem" in the community that requires "clarification and moral leadership" (Dickey & Miller, 2005). Mikawa and colleagues (1992) found that religion had no influence on condom use among Latino men and women, although 85% identified as Catholic. Contraception was seen as sinful behavior among a sample of Nicaraguan men and women (Sternberg, 2000). Dickey and Miller (2005) indicated however, that 70% of American Catholics felt the Pope should encourage contraceptive use, even though the Church's stand against contraception as "intrinsically evil" has remained the same since 1968. The Catholic Church's inability to address the sexual health needs of the community has resulted in Latin American Catholics converting to other religious denominations, particularly charismatic Christian denominations, such as Protestant, Pentecostal, and Evangelical churches.

Limited research has explored the impact that religious institutions have on reinforcing stigmas and discrimination against Latino MSM. Stokes and Peterson (1998) conducted a qualitative study on the implications that homophobia has on risks for HIV among black MSM (n = 76) 18 to 29 years of age in Atlanta and Chicago. Although the study's population was black MSM, findings may be useful to gain greater insight among Latino MSM since both populations are categorized as historically oppressed, marginalized due to their sexuality, and have historical religious influence. The participants stated that they perceived the black community as having greater levels of

homophobia than white people, which caused some participants to internalize negative attitudes towards homosexuals (Stokes & Peterson, 1998). Participants also mentioned that despite their active involvement with the black church, many encountered homophobic attitudes from the church (Stokes & Peterson, 1998). The researchers (Stokes & Peterson 1998, p. 283-4) indicate that black MSM remained involved with the church because "…The church is a resource for coping with oppression, going to church helps some feel better about their *sinful* behavior, attending church helps disguise one's homosexuality, and the church is a good place to meet men." Black MSM also mentioned that the church plays a significant role in reinforcing homophobia in the community (Stokes & Peterson, 1998).

Fullilove and Fullilove (1999) conducted a qualitative study exploring the influence of the black church and its implications on HIV prevention among black MSM. Focus groups were conducted in San Francisco, New York, and Washington, D.C. during the Black Church National Training and Leadership Conference (Fullilove & Fullilove, 1999). Homosexuals had a difficult relationship with the church because their sexuality was perceived as the most sinful act, yet they played a significant role in bringing religious members closer to God (Fullilove & Fullilove, 1999). Furthermore, some participants emphasized the hypocrisy of the church and how some ministers participated in homosexual behavior, yet preached the abomination of homosexuality (Fullilove & Fullilove, 1999). The implications of stigma were so profound for some black MSM that it caused them to distance themselves from their congregation, which resulted in depression and isolation (Fullilove & Fullilove, 1999). Overall, the black church has

been found to reinforce homophobia in the community and has impeded efforts to address HIV in the community (Fullilove & Fullilove, 1999).

Cotton and colleagues (2006) conducted a quantitative study to explore the influence that HIV/AIDS had on religion and spirituality among 347 participants (52% white and 48% black, 87% women and 13% men) that were diagnosed with HIV/AIDS. HIV/AIDS caused participants (50%) to think that their spiritual or religious beliefs had lengthened their life or helped them live longer (Cotton et al., 2006). Overall, 24% of participants felt alienated by a religious group due to their HIV/AIDS status, but 41% of the white participants were more likely to feel alienated compared to 21% of the black participants (Cotton et al., 2006). Since being diagnosed with HIV, 10% reported that they changed their place of worship to another congregation in the same religious group (Cotton et al., 2006).

Agate and colleagues (2005) reported that the main barriers encountered in promoting HIV prevention programs through faith-based communities were stigma, discrimination, and fear associated with HIV/AIDS. The public health department's partnership with religious institutions helped them designate their roles in HIV prevention and strengthened the quality of services for the community through Churches United to Stop HIV (CUSH). Agate and colleagues (2005) elaborated on the importance for faith-based leaders to invest and gain a sense of ownership to provide greater services for the community. Limited research (Agate et al., 2005; Silva & Guimarães, 2000) demonstrates the need for greater insight on HIV prevention initiatives taken by formal and informal religious institutions.

Varas-Díaz and colleagues (2010) interviewed 80 health professionals (i.e., medicine, nursing, psychology, social work) to complete an in-depth interview and 421 health professionals to complete a self-administered survey to explore religion's role on HIV/AIDS stigma in Puerto Rico. The qualitative interviews did not specifically inquire on issues related to religion, but 25% of the qualitative sample mentioned how religion influenced their perception of health (Varas-Díaz et al., 2010). One participant expressed how religion has been instilled into the Puerto Rican culture and teaches one to believe that "Homosexuality, lesbianism, and drug use were bad things" (Varas-Díaz et al., 2010, p.304). Another participant expressed how Christianity reinforced empathy for PLWHA and one's role as a Christian to care for the sick (Varas-Díaz et al., 2010). Participants reported conflict between their religious beliefs and their professional roles and the need to go against their personal beliefs in order to address the needs of a client (Varas-Díaz et al., 2010). Some saw HIV/AIDS as an act by God so that the individual was forced to reevaluate his/her relationship with God. Another participant saw it as a consequence of careless behavior (Varas-Díaz et al., 2010). The quantitative measures for the research study (Varas-Díaz et al., 2010, p.300) on religious experience were determined by two questions that asked: "How important is religion for you?" and "How often do you participate in religious activities?" Varas-Díaz and colleagues (2010) found that participants who identified that religion was important to them were more prejudiced against HIV/AIDS.

García and colleagues (2008) found in a qualitative study of gay, bisexual, and transgender Latinos that religion was synonymous with Latino culture. Religious beliefs and values were deeply rooted in Latino culture and reinforced by the family (García et

al., 2008). Mothers and grandmothers played an influential role in reinforcing religious beliefs within the family as well as involvement with the Catholic Church (García et al., 2008). Latino participants expressed that the realization of a homosexual identity during adolescence conflicted with religious beliefs and values, which resulted in them withdrawing from the Catholic Church (García et al., 2008).

> [O]ur participants described this period as difficult and conflictive, in that they tried to reconcile their sexuality with a religion that views homosexuality as sinful and unacceptable. Individuals' identity as good and moral beings is questioned and weakened due to traditional Catholic religious values. Some participants experienced rejection from their churches, as well as feeling of shame, guilt, and depression due to this conflict. Moreover, this conflict may be particularly intense because religion is tied to family and social practices. Thus, the conflict is not only about religious values, but also the individual's position in the family and wider society. (García et al., 2008, p.430)

Overall, García and colleagues (2008, p.430) found that adult resolution of the conflict between sexuality and religious beliefs could result in the person: 1) remaining Catholic; 2) converting to another religious denomination; 3) joining nontraditional religions or spiritual groups; or 4) abandoning organized religion. Returning to the Catholic Church resulted in participants disassociating their sexuality from the church, which resulted in not disclosing their sexuality or limiting their participation with their religious congregation (García et al., 2008). Participants that converted to another religious denomination joined other congregations that were supportive of the gay, lesbian, bisexual, and transgender community (García et al., 2008). Participants that joined spiritual groups were more likely to reside in San Francisco and less likely to have strong family ties within the city, which may have also been influenced by the culture climate of the environment (García et al., 2008). People who abandoned institutionalized religion had lower levels of spirituality (García et al., 2008).

Catholic respondents indicated that the Catholic Church regarded homosexual behavior as sinful as opposed to discriminating and/or stigmatizing against homosexuals (Kubiceck et al., 2009). Kubiceck and colleagues (2009) found that participants were conflicted about their religious beliefs and sexuality, which resulted in a disassociation with a religious affiliation. Family religious beliefs influenced participation in a congregation and participants reported feeling coerced to go to church, which caused them to feel highly anxious because sermons reinforced homophobia and condemned homosexuality (Kubiceck et al., 2009). Participants also encountered homophobia among religious family members, which manifested in internalized homophobia and a chronic sense of guilt and worthlessness (Kubiceck et al., 2009). In addition, participants reported that family members would shun them if they found out about their homosexuality and some would get kicked out of their homes (Kubiceck et al., 2009). A participant reported the following after being kicked out of his house and moving in with his brother who was a pastor at a church:

> My brother knew I was gay and when I broke out of my shell, I got more involved I would want to have Bible sessions at my house. And he liked the fact that I was being more involved but it's like he'll sometimes try to cut it short…So then we had a discussion about me, about me and my sexuality and he said that I am heavenly minded but no earthly good…Meaning I can think about God and pray about God and talk about God as much as I want but I am no earthly good because I am gay…I am a sinner. I have no purpose here. (Kubiceck et al., 2009, p.613)

The statement by the participant emphasizes the significant turmoil endured by people who are deeply engaged in the religious community when they encounter conflict due to their homosexuality. A sense of being unclean or living a sinful life has a detrimental effect on one's psyche, which may cause the person to develop internalized homophobia. A person's sense of worth is depleted as a result of living a sinful life and

being rejected by one's religious community based on sexuality, which may lead to a fatalistic approach towards life.

Practitioners can have an influential role in collaborating with religious leaders to prevent stigmas among highly marginalized populations such as homosexuals. Faith-based interventions addressing HIV in the community can develop youth groups that embrace diversity and reinforce a community of acceptance. GLBT alliance groups in religious congregations are a great way to introduce a safe space for youth to discuss issues related to sexuality and reinforce religious beliefs and values.

Overall, participants felt conflicted when they encountered homophobia in the church because they were raised in a religious household and taught that religion would protect them (Kubiceck et al., 2009). "The most frequently cited contradiction was between the idea that gay people will be punished by God and the concept that God is a loving, omniscient, perfect creator" (Kubiceck et al., 2009, p.618). Participants would question who they were and reported depression, suicidal ideation, substance abuse, and lack of eating or over eating to compensate for their feelings of despair and hopelessness (Kubiceck et al., 2009). A participant shared his struggle for coping with the conflicting religious rhetoric reinforcing homophobia and his sexuality:

> In middle school it was like I was so angry at myself because I was that and I couldn't accept it. So it was like religion was telling me to be one thing, society was telling me I had to be that one thing. I had to be straight and it made me angry. I took it out on a lot of people who were gay and it turned me into those people that were yelling on the streets...I would be like. "Faggot," or push people or get into fights, just stupid things. And I slowly went into a transition when I was in high school. I hid in the shadows…I slowly started to hate myself, hate religion, and hate everybody who believed in it because I was this and God made me like this. (Kubiceck et al., 2009, p.615)

Great attention has been paid to the influence of religion and spirituality among individuals and communities, but difficulties occur when defining and measuring attributed outcomes with religion and spirituality. Miller and Thoresen (2003) highlight how the existing literature on religion and spirituality utilize the concepts interchangeably without clearly defining either one. Researchers (Hall & Edwards, 2002; Pargament, Koenig, & Perez, 2000) have emphasized the need to utilize existing scales to strengthen theories on religion and spirituality. One such scale is the Religious/Spiritual Coping (RCOPE) scale which is a thorough assessment of religious coping based on religious theoretical paradigms. The following five theories were identified in the role of religion: Meaning – search for the meaning of life; Control – sense of control; Comfort/Spirituality – desire to connect to a higher being; Intimacy/Spirituality – social cohesiveness; and Transformation – perceived assistance of transition or transformation in a major life event (Pargament, Koenig, & Perez, 2000). Although the RCOPE is a comprehensive measure of religious coping, it does not differentiate the religious experience from the spiritual experience. Another scale, the Spirituality Well-Being Scale (SWBS), has received recognition from researchers (Hall & Edwards, 2002; Hill & Pargament, 2003; Tuck, McCain, & Elswick, 2001) in assessing levels of spiritual well-being through an individual (Existential Well-Being subscale) and religious (Religious Well-Being subscale) perspectives. Tuck, McCain, and Elswick (2001) explored scales that measure the relationship between spirituality and psychosocial factors among HIV positive adults and identified the Existential Well-Being as the most reliable subscale. The Spiritual Assessment Inventory (SAI) is distinguished in its ability to assess the quality of relationship associated with individual and social spirituality; it is comprised of six

subscales such as Awareness, Realistic Acceptance, Disappointment, Grandiosity, Instability, and Impression Management (Hall & Edward, 2002).

Religion and spirituality are complex phenomena and outcomes have been associated with them without clearly defining the concepts. This paper utilized Hill and Pargament's (2003) definitions for spirituality and religion. They define spirituality as an intrinsic search for what is sacred, which can be reinforced individually or with a group of people, for example within a religious congregation. Religion, on the other hand, reinforces an individual's search of the sacred with a group of people or to obtain non-sacred means through a sense of community and support. Hill and Pargament (2003) emphasized that the search process involved the ability to identify, articulate, maintain and transform what is sacred into daily life. The process of searching for the sacred takes the individual on a journey that reinforces religious involvement or causes them to seek an alternative approach to strengthen spiritual beliefs. Insight into the individual's process within a religious and spiritual context provides an understanding of how these factors influence one's psychological and behavioral processes (Hill & Pargament, 2003).

Pargament and colleagues (1988) described three styles of religious coping. The first is collaborative, which is an internal personal process where the individual asks for God's help in addressing a problem. The second is deferring, or an external approach by an individual waiting for a sign from God. Finally, self-directing is where an individual believes God has provided one with the ability to address one's own problems and is less influenced by traditional religious involvement. These three styles of religious coping explore the relationship between the individual and God, but do not identify the role between religion and spirituality in the coping process.

Summary

The literature demonstrates that there is limited information on the influence that social structures have in reinforcing discrimination and the implications for HIV/AIDS knowledge in the Latino community. HIV/AIDS interventions continue to have little success in preventing disproportionately higher HIV prevalence rates among communities of color. The epidemic continues to grow and disproportionately affects Latinos. This study further explored the recommendations made by researchers (Ayala, Husted, & Spieldenner, 2004; Battle, Bennett, & Shaw, 2004; Diaz, 1998) and considered the impact of social, cultural, and psychological issues on HIV transmission among Latinos. The historical section provided an overview of the power elite's conceptualization of homosexuality and how it has manifested into a social problem over the years.

An overview of the HIV/AIDS epidemic demonstrates how it has progressed and provides insight into how HIV prevalence rates stabilized for white MSM, but continued to spread in communities of color. Cohen (1999) provided a unique perspective on how the power elite failed to alert society about the HIV epidemic in its early stage. Black people and people of color did not believe that they were at risk of being infected with HIV because they thought it was a disease limited to gay white men. Black gay and lesbian activists raised awareness of HIV/AIDS in the community, despite the lack of attention from the media to the HIV problem in communities of color. Once government increased funding for HIVAIDS interventions, the black middle-class took control and further marginalized gays, lesbian, MSM, IDUs, and trangenders.

The historical perspective provided insight into how ideology is reinforced through stigmatizing people that do not adhere to prevailing social norms and indicates the impact that the power elite, including the gatekeepers (i.e., black middle class), can have in addressing a social problem such as HIV/AIDS among people of color. Sexual deviance theory and queer theory set the frame for the findings of this research study. Sexual deviance theory places an emphasis on how the power elite created and reinforced stigmas to oppress "deviants." The literature shows how maintaining beliefs and values in a civil society are based on principles from the power elite. Queer theory showed how white men developed and maintained patriarchic structures to protect their interests and maintain control of resources. An emphasis was placed on white heterosexual male privilege and oppression of "minorities."

The historical and theoretical sections shed light on how social structures are developed and reinforced in society. The literature indicated that despite the significant advances made in HIV/AIDS medical treatments, interventions have failed to maintain the momentum. HIV prevalence rates stabilized for white MSM, but continue to disproportionately impact communities of color. Homogenization of Latinos has been perceived as a significant barrier to providing culturally empowering HIV/AIDS interventions for Latinos. The Latino community is a diverse population of many ethnicities and cultures, but has been homogenized as one target population. Therefore, this research study highlights significant factors related to social structures and the HIV/AIDS epidemic for Latinos such as: HIV/AIDS among Latinos; race, ethnicity, and culture; Latinos and immigration; acculturation; *machismo*; sexual identity; and religion and spirituality.

Latinos are the largest population of color in the U.S. and they encounter huge obstacles in accessing resources such as employment, healthcare, and education. Latinos are the least likely to have a high school education and access to healthcare. Latinos also encounter xenophobic attitudes, which place greater obstacles in accessing resources. Poverty, unemployment, low levels of educational attainment, and limited access to healthcare are just some of the obstacles Latinos face, in addition to the growing HIV/AIDS epidemic. Many of the obstacles that Latinos experienced are due to social structures reinforcing oppression among "minorities" and development of policies to determine who is worthy of accessing resources.

Acculturation is another factor to consider when shedding light on issues that affect Latinos due to immigration status and years living in the country. As the literature demonstrates, lower levels of acculturation are associated with lower levels of HIV/AIDS knowledge. Therefore, this study sought to explore further the diversity among Latinos related to acculturation and ethnic identity and its implications for religiosity, discrimination, and HIV/AIDS knowledge.

A focus on the concept *machismo* is important because it appears in various research articles focused on Latino men. The emphasis on social structures and reinforcement of stigmas among historically oppressed populations required further insight into the "*machismo*" concept and implications for Latino men. Similar traits such as substance abuse, domestic violence, and homophobic attitudes exist in every race and culture, but the Latino male has been stigmatized as a cultural anomaly. A review of how the *machismo* stigma was developed and reinforced demonstrates the significance that colonialism and religious institutions have had in reinforcing oppression among Latino

men. Additional insight is necessary to develop culturally empowering interventions for Latino men that do not reinforce stigmas, which subsequently might increase susceptibility to HIV transmission.

Insight into the *machismo* concept also required information related to gender roles and sexual identity among Latino men. Gender roles and sexual identity reinforce the power elite's patriarchic structure and effeminate traits among men are seen as a sign of weakness. Latino MSM who are able to "pass" as straight enjoy heterosexual privileges of power and dominance, unlike their effeminate MSM counterparts who are subjected to submission and stigmatized as a "puto" and/or "joto." MSM of color also feel conflicted because they are supposed to present a strong virile male, which contradicts their role in the community if they have sexual encounters with other males. The community reinforces ideology about what is appropriate and inappropriate; the norms must be maintained in order to show the power elite that they are just as civil as them.

Religion has also played a momentous role in reinforcing gender roles and sexual identity. Religion has been integral to Latino culture. Churches were influential during the colonization of the Americas and are still influential today. Natives were prohibited from practicing their religious beliefs and forced to convert to Catholicism. Religious ideology guided society as to what cultural norms to reinforce; people who disagreed were condemned to hell. The church presents significant obstacles in addressing the HIV/AIDS epidemic due to its religious ideology condemning homosexuality as an abomination and the Catholic Church insisting that members refrain from using contraceptives. The literature on religion and HIV/AIDS showed the influence that

religion has on individuals, but there is a gap in the literature regarding the power that religious institutions have in reinforcing social stratification in the community and further marginalizing people such as MSM, IDU, and sex workers.

The literature indicated that being a member of a marginalized group (e.g., immigrant, PLWHA, homosexual) increases one's susceptibility to HIV transmission and hinders one's access to resources. A greater understanding is required of the heterogeneity of Latinos and the implications for prevention and treatment of HIV/AIDS. Gaining insight into how social structures are reinforced to subjugate marginalized members within a historically oppressed population will strengthen initiatives in providing effective services for Latinos. The implications of this research for social workers are that the findings increase the professions knowledge of ways to address the needs of Latinos at the individual and community level through a strengths based approach for interventions addressing HIV/AIDS.

7. Research Methodology

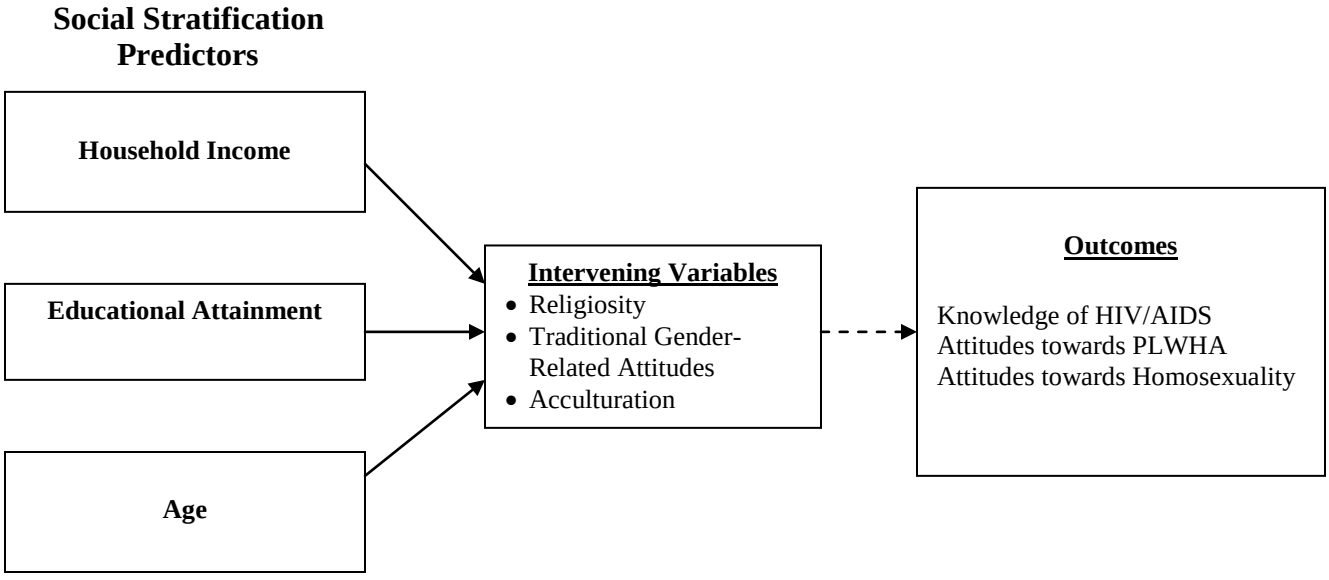
7.1. *Research Design and Rationale*

HIV/AIDS interventions have taken an individualistic and group-based cognitive-behavioral approach to educate individuals about HIV/AIDS transmission, prevention and treatment. More recently, however, community-based interventions (CDC, 2009) have been gaining ground and interventions with tested efficacy (i.e., Evidence Based Interventions) are being used to prevent HIV. Existing HIV/AIDS interventions have had limited success in curtailing the epidemic among people of color. Researchers have emphasized the need to look beyond behavior and take into consideration how social, cultural, and psychological issues affect HIV transmission in communities of color. The literature review illustrated initiatives taken on exploring the influence that sociocultural factors have on the HIV/AIDS epidemic among Latinos. The literature review provided information on the plight of marginalized Latino populations (e.g., MSM, IDU, sex workers), but does not show how social stratification reinforces inequality, stigmatization, and oppression within a historically oppressed population and how these factors are associated with HIV/AIDS.

Homogenization of the Latino population has also impeded efforts to lower HIV prevalence rates among Latinos. This research study explored the implications of power and status (i.e., household income, age, educational attainment) among Latinos. An emphasis on power and status are significant factors because they provide essential information on how social stratification is reinforced within a historically oppressed population such as Latinos.

The following figure demonstrates a conceptual model for the relationship among variables influencing HIV prevention in the Latino community. The left column indicates the three social stratification predictors based on power and status: household income, educational attainment, and age. The intervening variables are categorized into three main groups: 1. Religiosity – focuses on religious institutions as a social structure and the influence intrinsic and extrinsic religiosity has on reinforcing attitudes towards PLWHA and homosexuals; 2. Traditional gender-related attitudes – places an emphasis on reinforcing designated masculine and feminine gender roles among Latinos; and 3. Acculturation – places an emphasis on the respondent's utilization of language and desired social network in reinforcing inequality within a historically oppressed population (i.e., Latinos). The outcome variables will provide information on how knowledge of HIV/AIDS and attitudes towards PLWHA and homosexuality are influenced by the predictor and intervening variables.

Figure 1: Conceptual Model for Factors Influencing Attitudes among Latinos Towards PLWHA and Homosexuals



The researcher applies power elite theory and queer theory to demonstrate the influence that power and status (i.e., age, household income, educational attainment) has on social stratification (i.e, religiosity, traditional gender-related attitudes, acculturation) within a historically oppressed population (i.e., Latinos) and implications for attitudes towards PLWHA and homosexuals. This study uses an exploratory and descriptive quantitative non-experimental research design. A convenience sample recruited via numerous organizations completed an anonymous online survey. Therefore, the following three hypotheses were examined:

H_1 Latinos that report greater levels of HIV/AIDS knowledge will have:

- Reported a younger age
- Greater levels of household income
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of levels of educational attainment.

H_2 Latinos that report lower levels of negative attitudes towards PLWHA will have:

- Reported a younger age
- Greater levels of household income
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of levels of educational attainment.

H_3 Latinos that report lower levels of negative attitudes towards homosexuals will have:

- Reported a younger age
- Greater levels of household income
- Greater levels of acculturation.
- Lower levels of religiosity.
- Lower levels of traditional gender-related attitudes.
- Greater levels of educational attainment.

7.2. *Data Collection Procedures*

Latinos were recruited from the general population in order to gain a better understanding of how beliefs and values are reinforced through social structures and their implications for highly marginalized groups (e.g., PLWHA, MSM) within a historically oppressed population (e.g., Latinos). The target population for this research study was the Latino population in the U.S. aged 18 years and older.

Eligible participants were informed that the survey was anonymous and no identifiable information would be linked to the survey. Participants were informed that they would also have an opportunity to submit their contact information for a lottery drawing at the end of the survey.

A lottery was administered to provide an incentive for participants to complete the survey and 24 randomly selected winners received one of the following prizes totaling $1,100 (4: $100 prizes; 8: $50 prizes; and 12: $25) in gift cards or money orders. A separate link was created for participants to submit their contact information for the lottery drawing in a separate database not linked to the questionnaire to ensure that their responses remained anonymous. The database generated a unique identification number for each entry and the winning lottery numbers were posted on the research website. Personalized emails were sent to everyone that entered the lottery along with their unique lottery number. Participants were directed to refer to the research website for notification of winning numbers and winners received a personalized email with instructions on how to claim the prize. All lottery entries were destroyed once winners claimed their prize and winners were informed that they needed to submit a receipt of payment with their signature and contact information for auditing purposes for the funder (i.e., Doctoral

Student Research Grant at CUNY – Graduate Center). Approximately 3 people were selected as winners, but did not claim their prize. A few attempts were made to contact the winners and if they did not respond within 30 days the prize was forfeited and another winner was selected for the prize. Winners that claimed their prize received a Visa gift card or money order shipped to their preferred mailing address. The majority of the winners selected a money order to avoid a $5 convenience fee for the Visa gift card.

An email advertisement (refer to Appendix D) was sent out in English and Spanish to encourage Latinos to participate in a 30 minute self-administered online survey. The email specified the recruitment criteria: 18 years of age or older and identifying as Hispanic, Latino, or from a Latin American country. The following organizations and institutions emailed the advertisement via their list-serve with a brief description of the study and a link to participate in the research study:

- Alianza at Northwestern University
- Baccalaureate Program Directors for Social Workers
- Latin American Recruitment and Educational Services Program at UIC
- Latino Alumni Association of Columbia University
- Latinos Unidos at DePaul University
- Organization of Latin American Students at Chicago State University
- Proyecto Pa'Lante at Northeastern Illinois University

A link was given in English and Spanish for people to complete the survey in their desired language. A screener was utilized to determine eligibility for the study (i.e., 18 years or older, Latino/Hispanic descent) and biological sex to designate appropriate questions for sexual risk behaviors and questions. A consent form (refer to Appendix E) was provided for people that screened eligible for the study. People that screened ineligible were thanked for their interest and redirected to the research study website, which was open to the general public. A general website was created for people (eligible

and ineligible) interested in the findings of the study and to announce the winning lottery numbers. The study website provided an opportunity for Latino organizations to post any events that may be of interest for the Latino community. Participants were encouraged to forward the email description of the study with the link to their social network in an attempt to recruit participants from outside of the organizations and institutions that were targeted in the electronic list-serves.

7.3. ***Measures***

The survey consisted of seven existing measures: 1) Acculturation Scale; 2) Gender Attitudes Scale; 3) Revised Age Universal Intrinsic-Extrinsic Scale; 4) The Spirituality Well-Being Scale; 5) HIV/AIDS Knowledge Scale; 6) AIDS Attitude Scale; and 7) Attitudes toward Homosexuals. Additional items were included to further explore sexual practices and behaviors, religiosity, and demographic characteristics. The surveys were translated from English to Spanish and back translated from Spanish to English to ensure accurate translation, with the exception for the acculturation and gender attitudes scales which were already available in Spanish. The following section provides information regarding the scales selected for the research study.

7.3.1. *The Acculturation Scale* is a highly-regarded 12-item Likert scale that assesses levels of acculturation among Latinos by determining level of language use, media use, and ethnic social relations (Marin et al., 1987). The first section of the scale focuses on language and media response categories with the following values: 1-Only Spanish, 2-More Spanish than English, 3-Both Equally, 4-More English than Spanish, and 5-Only English. The second section of the scale focuses on social network categories with the

following values: 1-All Latinos, 2-More Latinos than Americans, 3-About Half & Half, 4-More Americans than Latinos, and 5- All Americans. The scoring ranges for acculturation were from 12 (low acculturation) to 60 (high acculturation). The face validity of the questions related to acculturation among Latinos is accurate, as indicated by the question: "What language(s) do you usually speak with your friends?" *The Acculturation Scale's* internal reliability ranked lower in the present study with an alpha coefficient of .88 (Table 4) when compared to the cited research study, which received an alpha coefficient of .92 (Marin et al., 1987). The subscale for language had an alpha coefficient of .87, the subscale for media had an alpha coefficient of .84, and the subscale for social network had an alpha coefficient of .81 for internal reliability. Overall, 93.3% (N = 291) completed the 12 item scale measuring acculturation.

Table 4: Acculturation Scale

Items	Mean	SD	N
In general, what language(s) do you read and speak?	3.56	.82	291
What was the language(s) you used as a child?	2.57	1.39	291
What language(s) do you usually speak at home?	3.30	1.23	291
In which language(s) do you usually think?	3.76	1.06	291
What language(s) do you usually speak with your friends?	3.81	.94	291
In what language(s) are the T.V. programs you usually watch?	4.04	.91	291
In what language(s) are the radio programs you usually listen to?	3.64	1.14	291
In general what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?	3.92	.84	291
Your close friends are	2.59	.98	291
You prefer going to social gatherings/parties at which people are	2.67	.77	291
The persons you visit or who visit you are	2.52	1.00	291
If you could choose your children's friends you would want them to be	2.89	.53	291

7.3.2. *The Gender Attitudes Scale* is a reliable 7-item Likert scale that assesses levels of gender role and equality among Latinos (Herek & Gonzalez-Rivera, 2006). The 7 items have the following response values: 1-strongly disagree, 2-moderately disagree, 3-disagree, 4-agree, 5- moderately agree, and 6- strongly agree. The scoring for gender related attitudes ranges from 7 (low traditional gender-related attitudes) to 42 (high traditional gender-related attitudes) for overall traditional gender-related attitudes. The face validity of the questions related to gender-related attitudes among Latinos is accurate, as indicated by the question: "Latin women should obey their husbands." *The Gender Attitudes Scale's* internal reliability ranked higher in the present study with an alpha coefficient of .83 (Table 5) when compared to the cited research study, which received an alpha coefficient of .80 (Herek & Gonzalez-Rivera). Overall, 98.1% (N = 306) completed the seven item scale measuring gender attitudes.

Table 5: Gender Attitudes Scale

Items	Mean	SD	N
Latin women should obey their husbands.	2.14	1.363	306
Men should be in charge of the family's finances.	2.18	1.255	306
Latin men need more freedom then Latin women.	1.78	1.073	306
A woman should be understanding if her husband has extramarital affairs.	1.48	.966	306
It is natural for men to be more violent than women.	2.36	1.451	306
Latin women should make more sacrifices than men.	1.66	1.031	306
In Latin families, it is the man's job to protect the family.	3.45	1.661	306

7.3.3. *The Revised Age Universal Intrinsic-Extrinsic Religiosity Scale* (Revised I-E Religiosity Scale: Table 6) is a reliable 20-item close ended instrument that measures levels of religiosity among religious and nonreligious groups (Maltby & Lewis, 1996). The first item is "I would prefer to go to church…" with the following response values: 0-Never, 1-a few times a year, 2-Once every month or two, 3-Two or three times a

month, 4-Once a week, and 5-More than once a week. The remaining 19 items have the following response values: 1-No, 2-Not certain, and 3-Yes. Therefore, an overall score of religiosity will range from 19 (low religiosity) to 62 (high religiosity). The scoring for the 12 extrinsic religiosity items ranges from 12 (low extrinsic religiosity) to 36 (high extrinsic religiosity). The scoring for 8 intrinsic religiosity items ranges from 7 (low intrinsic religiosity) to 26 (high intrinsic religiosity), which also includes a five point item for whether or not the subject prefers to go to church.

Table 6: Revised I-E Religiosity Scale

Items	Mean	SD	N
I would prefer to go to church	2.18	1.63	271
I enjoy reading about my religion.	2.19	.84	271
I go to church because it helps me make friends.	1.20	.53	271
It doesn't matter what I believe so long as I am good.	2.28	.87	271
Sometimes I have to ignore my religious beliefs because of what other people might think of me.	1.22	.57	271
It is important for me to spend time in private thought and prayer.	2.37	.86	271
I have often had a strong sense of God's presence.	2.42	.78	271
I pray mainly to gain relief and protection.	2.08	.94	271
I try to live all my life according to my religious beliefs.	1.89	.90	271
What religion offers me most is comfort in times of trouble and sorrow.	2.12	.92	271
My religion is important to me because it answers many questions about the meaning of life.	1.92	.89	271
I would rather join a Bible study group than a church social group.	1.48	.71	271
Prayer is for peace and happiness.	2.42	.84	271
Although I am religious, I don't let it affect my daily life.	1.79	.88	271
I go to church mostly to spend time with my friends.	1.08	.35	271
My whole approach to life is based on my religion.	1.43	.75	271
I go to church mainly because I enjoy seeing people I know there.	1.18	.53	271
I pray mainly because I have been taught to pray.	1.59	.85	271
Prayers I say when I am alone are as important to me as those I say in church.	2.45	.85	271
Although I believe in my religion, many other things are more important in life.	2.22	.84	271

Religious institutions can reinforce religious ideology and/or give people a sense of community. Hill and Pargament (2003) indicate that religion reinforces the search of the sacred with a group of people (intrinsic religiosity) or to obtain a non-sacred means through a sense of community and support (extrinsic religiosity). The Revised I-E Scale looks at the impact religious institutions have on individuals' levels of intrinsic and extrinsic religiosity. The face validity of the questions related to the intrinsic scale is accurate as indicated by the question: "I try to live all my life according to my religious beliefs." The internal consistency reliability is good (alpha coefficient of .89) for the intrinsic scale. The face validity of the questions related to the extrinsic scale are accurate, as indicated by the question: "I go to church because it helps me make friends." The internal consistency reliability is good (alpha coefficient of .87) for the extrinsic scale as well. *The Revised I-E Scale* in the present research study received an overall internal reliability alpha coefficient of .79, but rated higher for the intrinsic religiosity (alpha coefficient .83) subscale when compared to the extrinsic religiosity subscale (alpha coefficient .66). Overall, 86.9% (N = 271) completed the twenty-item scale measuring levels of intrinsic and extrinsic religiosity.

7.3.4. *The Spirituality Well-Being Scale* (SWBS: Table 7) is a 20-item Likert scale composed of two subscales (10 items for each subscale); the *Religious Well-Being Scale* (RWBS) and the *Existential Well-Being Scale* (EWBS) (Ellison & Smith, 1991). The 20 items have the following response values: 1-strongly disagree, 2-moderately disagree, 3-disagree, 4-agree, 5- moderately agree, and 6- strongly agree. The scoring for SWBS ranges from 20 (low spiritual well-being) to 120 (high spiritual well-being) for overall

spiritual well-being. The RWBS measures one's relationship with God and the EWBS measures one's relationship with self, community, and others (Hall & Edwards, 2002; Hill & Pargament, 2003).

Spirituality is defined as one's intrinsic search for what is sacred, which can be reinforced individually or with a group of people such as a church, ministry, or synagogue (Hill & Pargament, 2003). This research study distinguished religiosity from spirituality, to demonstrate the influence that religious institutions have on reinforcing beliefs in the community. Therefore, "Religious Well-Being" for the SWBS will be referred to as "Intrinsic Spiritual Well-Being" in this study, which places an emphasis on one's relationship with God.

The face validity of the questions related to intrinsic spiritual well-being is accurate, as indicated by the question: "I believe that God loves me and cares about me." The internal consistency reliability has an alpha coefficient of .87 for the intrinsic spiritual well-being. The face validity of the questions related to the EWBS is accurate, as indicated by the question: "I feel that life is a positive experience." The internal consistency reliability has an alpha coefficient of .78 for the EWBS. The *SWBS* scale received an overall internal reliability alpha coefficient of .90 in the present study (Table 7), but the intrinsic spirituality subscale rated higher (alpha coefficient .92) when compared to the extrinsic spirituality subscale (alpha coefficient .82). Ellison and Smith (1991) also indicated a higher internal reliability for the intrinsic spirituality subscale (alpha coefficient .87) when compared to the extrinsic spirituality subscale (alpha coefficient .78). Overall, 91% (N = 284) completed the twenty item-scale measuring intrinsic and extrinsic spirituality.

Table 7: Spiritual Well-Being Scale (SWBS)

Items	Mean	SD	N
I don't find much satisfaction in private prayer with God.	4.33	1.67	284
I don't know who I am, where I come from, or where I am going.	4.61	1.54	284
I believe that God loves me and cares about me.	4.67	1.47	284
I feel that life is a positive experience.	4.87	1.12	284
I believe that God is impersonal and not interested in my daily situations.	4.31	1.64	284
I feel unsettled about my future.	3.90	1.50	284
I have a personally meaningful relationship with God.	4.00	1.47	284
I feel very fulfilled and satisfied with life.	4.41	1.17	284
I don't get much personal strength and support from my God.	4.21	1.55	284
I feel a sense of well-being about the direction my life is headed in.	4.46	1.22	284
I believe that God is concerned about my problems.	4.12	1.50	284
I don't enjoy much about life.	4.81	1.44	284
I don't have a personally satisfying relationship with God.	4.05	1.58	284
I feel good about my future.	4.55	1.15	284
My relationship with God helps me not to feel lonely.	3.88	1.46	284
I feel that life is full of conflict and unhappiness.	3.90	1.38	284
I feel most fulfilled when I'm in close communion with God.	3.66	1.48	284
Life doesn't have much meaning.	4.81	1.53	284
My relation with God contributes to my sense of well-being.	4.04	1.48	284
I believe there is some real purpose for my life.	5.12	1.07	284

7.3.5. The *HIV/AIDS Knowledge Items Scale* was extracted from the National Health Interview Survey (NHIS) (CDC, 2004). The 20-item close ended questions measure one's knowledge about HIV/AIDS and modes of transmission. The first subsection of the scale has 11 items with True or False responses. The second subsection has 9 items with Likely or Unlikely responses. A value of 0 was designated for incorrect responses and 1 for correct responses. The scoring for HIV/AIDS knowledge ranges from 0 (low HIV/AIDS knowledge) to 20 (high HIV/AIDS knowledge) for overall HIV/AIDS knowledge. Overall the face validity of the questions related to HIV/AIDS knowledge is accurate, except for the following two questions which were revised to include "without a

condom": "Any person with HIV can pass it on to someone else during sexual intercourse [without a condom]" and "How likely do you think that a person will get HIV from the following: Engaging in anal sex [without a condom]." The Kuder Richardson – 20 was used to determine the internal consistency reliability (.63) for the dichotomous items in the HIV/AIDS Knowledge Item Scale.

7.3.6. *The AIDS Attitude Scale – Generic version* (AAS-G: Table 8) is an adaptation for the general public from the AIDS Attitude Scale that was originally developed for healthcare professionals (Froman & Owen, 2001). The AAS-G instrument is a 21-item Likert scale that measures levels of avoidance (14 items) and empathy (7 items) towards PLWHA. The 21 items have the following response values for levels of avoidance and empathy towards PLWHA: 1-strongly disagree, 2-moderately disagree, 3-disagree, 4-agree, 5- moderately agree, and 6- strongly agree. The scoring for levels of avoidance for PLWHA ranges from 14 (low levels of avoidance for PLWHA) to 84 (high levels of avoidance for PLWHA). The scoring for levels of empathy for PLWHA were reverse coded and ranged from 7 (low levels of empathy for PLWHA) to 42 (high levels of empathy for PLWHA). A combined score ranging from 21(low levels of negative attitude for PLWHA) to 126 (high levels of negative attitude for PLWHA) would indicate overall negative attitudes for PLWHA. The face validity of the questions related to avoidance towards PLWHA is accurate, as indicated by the question: "I'm worried about getting AIDS from social contact with someone." The internal consistency reliability is good (alpha coefficient of .88) for the multi-item scale measuring levels of avoidance towards PLWHA. The face validity of the questions related to empathy towards PLWHA

is accurate, such as: “I think patients with AIDS have the right to the same quality of care as any other patient.” The internal consistency reliability is good (alpha coefficient of .88) for the multi-item scale measuring levels empathy towards PLWHA. The AAS-G scale received an overall internal reliability alpha coefficient of .90 in the present study (Table 8). The subscale measuring avoidance towards PLWHA received an alpha coefficient of .87 in the present study and an alpha coefficient of .88 in the study conducted by Froman and Owen (2001). The subscale measuring empathy towards PLWHA received an alpha coefficient of .83 in the present study and an alpha coefficient of .88 in the study conducted by Froman and Owen (2001). Overall, 91.7% (N = 286) completed the 21 item-scale measuring attitudes towards HIV/AIDS

Table 8: AIDS Attitude Scale (AAS-G)

Items	Mean	SD	N
Most people who have AIDS have only themselves to blame.	2.19	1.28	286
Most people who have AIDS deserve what they get.	1.49	.90	286
Hospital patients who are HIV positive should not be put in rooms with other patients.	2.30	1.41	286
If I had to have contact with someone with AIDS, I would worry about putting my family and friends at risk.	2.44	1.46	286
Young children should be removed from the home if one of the parents is HIV positive.	1.69	.99	286
I think patients with AIDS have the right to the same quality of care as any other patient.	1.51	1.06	286
It is especially important for hospital patients with AIDS to be treated in a caring manner.	1.76	1.20	286
I think people who are injection drug users deserve to get AIDS.	1.72	1.00	286
I think women who give birth to babies who are HIV positive should be prosecuted for child abuse.	1.92	1.16	286
Homosexuality should be illegal.	1.53	1.06	286
I feel more sympathetic toward people who get AIDS from blood transfusions than those who get it form injection drug abuse.	3.21	1.70	286
A homosexual hospital patient's partner should be accorded the same respect and courtesy as the partner of a heterosexual patient.	1.57	1.07	286
Hospital patients with AIDS should be treated with the same respect as any other patient.	1.57	1.08	286
If I found out that a friend of mine was a homosexual, I would not maintain the friendship.	1.40	1.04	286
I'm worried about getting AIDS from social contact with someone.	1.59	1.03	286
I am sympathetic toward the misery people with AIDS experience.	2.20	1.34	286
I would like to do something to make life easier for people with AIDS.	2.16	1.09	286
I would do everything I could to support people with AIDS.	2.28	1.15	286
Children or people who get AIDS from blood transfusions are more deserving of treatment than those who get it from injection drug abuse.	2.61	1.63	286
I would be worried about my child getting AIDS if I knew that one of his teachers was a homosexual.	1.61	1.11	286
I have little sympathy for people who get AIDS from sexual promiscuity.	2.15	1.27	286

7.3.7. *Attitudes toward Homosexuality* (Table 9) is a 12 multi-item scale that measures attitudes towards homosexuality (Altmeyer & Hunsberger, 1992). The 12 items have the following response values for levels of attitudes toward homosexuals: 1-strongly disagree, 2-moderately disagree, 3-disagree, 4-agree, 5- moderately agree, and 6- strongly agree. The scoring for levels of attitudes toward homosexuality ranges from 12 (low levels of negative attitude towards homosexuality) to 72 (high levels of negative attitude towards homosexuality). The face validity of the questions related to avoidance towards PLWHA is accurate, as indicated by the question: "Homosexuals should never be given positions of trust in caring for children." The internal consistency reliability (alpha coefficient of .89) in this study received the same score as the cited study for the multi-item scale measuring attitudes towards homosexuals (Altmeyer & Hunsberger, 1992). Overall, 95.5% (N = 298) completed the twelve item-scale measuring gender attitudes.

Table 9: Attitudes towards Homosexuality Scale

Items	Mean	SD	N
I won't associate with known homosexuals if I can help it.	1.49	1.02	298
The sight of two men kissing does NOT particularly bother me.	2.74	1.67	298
If two homosexuals want to get married, the law should let them.	2.36	1.70	298
Homosexuals should be locked up to protect society.	1.38	.85	298
Homosexuals should never be given positions of trust in caring for children.	1.57	1.03	298
I would join an organization even though I knew it had homosexuals in its membership.	2.06	1.57	298
In many ways, the AIDS disease currently killing homosexuals is just what they deserve.	1.42	.89	298
Homosexuality is "an abomination in the sight of God."	1.98	1.48	298
Homosexuals have a perfect right to their lifestyle, if that's the way they want to live.	2.07	1.61	298
Homosexuals should be forced to take whatever treatments science can come up with to make them normal.	1.46	.94	298
People should feel sympathetic and understanding of homosexuals, who are unfairly attacked in our society.	2.11	1.48	298
I wouldn't mind being seen smiling and chatting with a known homosexual.	2.00	1.60	298

7.4. *Human Subjects*

Participants were required to review the informed consent and indicate that they agreed to participate in the anonymous internet survey. The consent document stated that the risks from participating in the study were no more than those encountered in everyday life. They were also informed that some questions could make participants feel minor discomfort or embarrassment, which should not be greater than what they might experience in their daily lives. Participants were informed that they could choose not to answer any particular question and/or stop completing the questionnaire at any time.

No personal identifiers were linked to data and the questionnaires were anonymous. Participants also received contact information for the principal investigator, faculty advisor, and IRB office to address any questions or concerns they had about the study. Entries for the lottery drawing were collected through a separate database that generated a lottery number, which was not connected to an individual's completed survey. Participants had the option to print and mail in their lottery entry if they were concerned about their personal information being linked to their completed survey or unauthorized parties accessing their information online. Only one participant mailed in a lottery entry.

7.5. *Data Analysis Strategy*

All quantitative data were managed and analyzed using SPSS. Univariate, bivariate, and multivariate analyses were conducted to explore relationships between predictor, intervening and outcome variables. Univariate analyses were conducted for all independent and dependent variables. Bivariate analyses were conducted to assess the relationship between independent and intervening variables (i.e., religiosity,

acculturation, gender attitudes, educational attainment, household income, age), and dependent variables (i.e., HIV/AIDS knowledge, attitudes towards PLWHA, attitudes towards homosexuality).

Multivariate regression analyses were conducted to assess the predictors of HIV/AIDS knowledge, attitudes towards AIDS, and attitudes towards homosexuality. The independent variables for the multiple regression analyses are: household income, educational attainment, age, religiosity, acculturation, and gender attitudes. The dependent variables are: HIV/AIDS knowledge, attitudes towards PLWHA, and attitudes towards homosexuality.

7.5.1. *Data Cleaning and Transformations*: The Principal Investigator cleaned the data and 76 participants (19.6%) that did not complete the following measures (approximately 102 items) were removed from the data analysis: Acculturation Scale, Gender Attitudes Scale, Revised Intrinsic-Extrinsic Religiosity Scale, Spiritual Well-Being Scale, HIV/AIDS Items Scale, AIDS Attitude Scale, and Attitudes towards Homosexuality Scale.

The research study initially attempted to recruit 400 Latino participants through advertisements via the internet within a three month period (January 29th through April 22nd, 2011). A total of 487 people (72.9% females, 26.3% males, and .8% no response) accessed the website. Therefore, 388 people that accessed the website screened eligible, and consented to participate in the study, but 312 participants completed the survey.

The lack of responses to the research study could be attributed to multiple factors such as perceived insufficient compensation for their time, length of the survey, internet

complications, or premise of the research study. The lottery drawing however, provided an incentive for most people to complete the survey online; 290 people (93%) enrolled for the lottery drawing. Participants were able to save their responses and return to complete the survey, but three people reported via email that they had internet problems when returning to finish partially completed surveys (incomplete data was excluded from the analysis). A few individuals expressed that they were agnostic or atheist and refused to answer any questions related to religion and/or spirituality.

Overall, convenience sampling allowed for greater access to the target population. The survey was self-administered and participants had the luxury to complete the survey in a familiar and comfortable setting during the day and/or night. The survey was available in English as well as Spanish to address any potential language barriers and increase participation from the target population. Alumni associations affiliated with the Principal Investigator strengthened recruitment initiatives from Latino college students in the community.

8. Results

8.1. *Demographic Characteristics*

Findings are reported on a total sample size of 312 participants. Almost two-thirds of the sample was female (74.4%), with a mean age of 32.8 (SD 9.3) and an age range of 21 to 64 (Table 10). A significant proportion of the sample had a high level of educational attainment (25.6% some college, 25.6% undergraduate degree, and 34% graduate school) and the majority of the surveys were completed in English (89.7%). Annual household income varied despite high levels of education: 28.5% reported $70,000 or more, 13.8% reported $30,000-39,999, 12.8% reported $20,000-29,999, and 10.9% less than $9,999. Slightly more than half the sample was single (52.9%) and 28.8% reported that they were married. The participants also indicated the following religious denominations: 59.9% Catholic, 17.6% no religion, 11.2% Christian, and 10.6% other. The majority of the participants identified with the Democratic Party (68.9%) followed by Liberal (12.8%) and Republican (6.1%). Sexual identity was predominantly heterosexual (77.2%) followed by gay/lesbian/homosexual/queer (15.4%) and bisexual (4.2%). Participants reported their race as Hispanic/Latino (74.7%) and White – Hispanic/Latino (14.1%).

Table 10: Demographic Characteristics of Dímelo Research Participants (N = 312)

Variable	No.	(%)	Missing No.	(%)
Biological Sex				
Female	232	(74.4)		
Male	80	(25.6)		
Language of Survey				
English	280	(89.7)		
Spanish	32	(10.3)		
Age 21-64 (Mean 32.8 & SD 9.3)	297	(95.2)	15	(4.8)
Marital Status			**7**	(2.2)
Single	165	(52.9)		
Married	90	(28.8)		
Divorced	14	(4.5)		
Separated	4	(1.3)		
Widowed	4	(1.3)		
Other	28	(9.0)		
Sexual Identity			8	(2.6)
Straight/Heterosexual	241	(77.2)		
Gay/Lesbian/Homosexual/Queer	48	(15.4)		
Bisexual	13	(4.2)		
Other	2	(0.6)		
Educational Attainment			8	(2.6)
Some High School or Lower	7	(2.2)		
GED	5	(1.6)		
High School Diploma	24	(7.7)		
Trade School	2	(0.6)		
Some College	80	(25.6)		
Undergrad Degree	80	(25.6)		
Graduate School	106	(34.0)		
Household Income			7	(2.2)
Less than 9,999	34	(10.9)		
10,000-19,999	22	(7.1)		
20,000-29,999	40	(12.8)		
30,000-39,999	43	(13.8)		
40,000-49,999	26	(8.3)		
50,000-59,999	27	(8.7)		
60,000-69,999	24	(7.7)		
70,000 or more	89	(28.5)		
Political Party Affiliation			12	(3.9)
Democrat	215	(68.9)		
Liberal	40	(12.8)		
Republican	19	(6.1)		
Other	26	(8.3)		
Religious Denomination			2	(0.7)
Catholic	187	(59.9)		
Christian	35	(11.2)		
No Religion	55	(17.6)		
Other	33	(10.6)		
Race			7	(2.2)
Hispanic/Latino	233	(74.7)		
White, Hispanic/Latino	44	(14.1)		
Black, Hispanic/Latino	11	(3.5)		
White, non-Hispanic/Latino	3	(1.0)		
African American	2	(0.6)		
Other	12	(3.8)		

8.2. *Univariate Analyses*

The univariate analysis for acculturation (Table 11) revealed that the majority of the sample read and speak more English than Spanish (51.4%) and both languages equally (30.2%), despite Spanish being used during childhood among 31.4% and more Spanish than English being used during childhood among 21.2%. The majority of the sample (85%) also had higher levels of education, which is reflected in the sample thinking (41.9%) and speaking to friends (48.5%) more in English than Spanish. Latinos overall preferred to socialize more with Latinos than Americans, but the majority of Latinos (79.7%), if given the choice to select friends for their children, preferred about half Latinos and Americans.

Table 11: Participant responses to the Acculturation Scale

Items	Scale (%)[6]					N
	1	2	3	4	5	
1. In general, what language(s) do you read and speak? (L)	1.3	8.7	30.2	51.4	8.4	311
2. What was the language(s) you used as a child?	31.4	21.2	18.3	17.6	11.5	312
3. What language(s) do you usually speak at home? (L)	8.8	21.5	18.6	34.5	16.6	307
4. In which language(s) do you usually think? (L)	3.9	10.4	17.9	41.9	26.0	308
5. What language(s) do you usually speak with your friends? (L)	2.3	9.7	17.8	48.5	21.7	309
6. In what language(s) are the T.V. programs you usually watch? (M)	1.0	8.1	11.0	46.8	33.1	308
7. In what language(s) are the radio programs you usually listen to? (M)	3.2	15.9	21.7	31.7	27.5	309
8. In general what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to? (M)	1.0	5.1	19.2	51.0	23.7	312
9. Your close friends are (S)	11.6	40.8	26.7	19.6	1.3	311
10. You prefer going to social gatherings/parties at which people are (S)	5.8	35.6	48.1	9.3	1.3	312
11. The persons you visit or who visit you are (S)	14.1	42.4	25.4	15.4	2.6	311
12. If you could choose your children's friends you would want them to be (S)	1.3	14.5	79.7	2.6	1.9	311

(L) – Language – 5 items (M) – Media – 3 items (S) – Social – 4 items

[6] Response categories for items 1 through 8 had the following values: 1-Only Spanish, 2-More Spanish than English, 3-Both Equally, 4-More English than Spanish, and 5-Only English. Response categories for items 9 through 12 had the following values: 1-All Latinos, 2-More Latinos than Americans, 3-About Half & Half, 4-More Americans than Latinos, and 5- All Americans.

The univariate analysis for traditional gender-related attitudes (Table 12) among Latinos dispels the myth of *marianismo* among Latinas. The majority of the sample was highly educated females (74.4%) and they strongly disagreed with the following statements: Latin women should obey their husbands (approximately 85% strongly disagreed to disagreed); men should be in charge of the family's finances (approximately 88% strongly disagreed to disagreed); Latin men need more freedom than Latin women (approximately 95% strongly disagreed to disagreed); a woman should be understanding if her husband has extramarital affairs (76.2% strongly disagreed); it is natural for men to be more violent than women (approximately 73% strongly disagreed to disagreed); and Latin women should make more sacrifices than men (approximately 96% strongly disagreed to disagreed). An additional finding indicated that approximately 55% of the sample agreed that it is a man's job to protect the family, but approximately 44% also disagreed with this statement.

Table 12: Participant responses to the Gender-Related Attitudes Scale

Items	Scale (%)[7]						N
	1	2	3	4	5	6	
1. Latin women should obey their husbands.	49.4	11.9	24.0	6.4	6.7	1.6	312
2. Men should be in charge of the family's finances.	45.2	9.0	34.2	5.8	5.2	.6	310
3. Latin men need more freedom then Latin women.	61.2	6.1	28.2	2.6	1.6	.3	312
4. A woman should be understanding if her husband has extramarital affairs.	76.2	3.5	17.0	1.9	.3	1.0	311
5. It is natural for men to be more violent than women.	45.7	8.4	19.3	18.3	7.1	1.3	311
6. Latin women should make more sacrifices than men.	66.6	5.8	23.5	2.6	1.3	.3	311
7. In Latin families, it is the man's job to protect the family.	20.0	11.0	13.5	28.7	12.9	13.9	310

[7] Response categories for the items had the following values: 1-Strongly Disagree, 2-Moderately Disagree, 3-Disagree, 4-Agree, 5-Moderately Agree, and 6-Strongly Agree.

Table 13 provides responses of the sample for overall religiosity, which is composed of *intrinsic* and *extrinsic* religiosity. Preference for frequency of church attendance showed 24.4% preferred to go to church once a week, 23.2% preferred a few times a year, and 21.2% preferred never to go to church. *Intrinsic religiosity*, which also included desire to go to church showed that: 65.6% would rather join a church social group than join a Bible Study group; 73.4% indicated that their whole approach to life is not based on their religion; and 67.9% indicated that prayers they say alone are just as important as the prayers they say in church. Respondents were divided on intrinsic religiosity items exploring the influence that religious beliefs have on influencing one's life for the following items: 57.2% indicated that it did not matter what they believe in as long as they are good; 48.5% indicated that they did not try to live their lives according to their religious beliefs; and 44.4% disagreed that religion is important to them because it answers many questions about the meaning of life. Only 46.6% enjoyed reading about their religion.

The items on *extrinsic religiosity* indicated the following: 85.9% did not go to church because it helps them make friends; 84.6% indicated that they did not sometimes have to ignore their religious beliefs because of what other people might think of them; 61.5% indicated that it was important for them to spend time in private prayer and thought; 61.1% agreed that they have often had a strong sense of God's presence; 64.1% agreed that prayer is for peace and happiness; 94.2% indicated that they do not go to church to mainly spend time with their friends; 88.6% also indicated that they do not go to church mainly because they enjoy seeing people they know at church; and 65.2% report that they do not pray mainly because they have been taught to pray. Half of the

sample (51.8%) indicated that “Although I am religious, I don’t let it affect my daily life” and 49.4% indicated that “Although I believe in my religion, many other things are more important in life.” The sample was split when asked if they pray mainly to gain relief and protection (40.8% disagreed and 46% agreed). Forty eight percent agreed that what religion offers them the most is comfort in times of trouble and sorrow, but 39% disagreed with the statement. Almost two-thirds of the sample (59.9%) identified as Catholic.

Table 13: Participant responses to the Revised Age Universal Intrinsic-Extrinsic Religiosity Scale

Item	Scale (%)[8]						N
	0	1	2	3	4	5	
1. I would prefer to go to church. (I)	21.2	23.2	12.2	12.5	24.4	6.4	311

Items cont.	Scale (%)			N
	No	Not Certain	Yes	
2. I enjoy reading about my religion. (I)	26.9	26.5	46.6	309
3. I go to church because it helps me make friends. (E)	85.9	8.7	5.5	311
4. It doesn't matter what I believe so long as I am good. (I)	26.4	16.4	57.2	311
5. Sometimes I have to ignore my religious beliefs because of what other people might think of me. (E)	84.6	8.4	7.1	311
6. It is important for me to spend time in private thought and prayer. (E)	25.6	12.9	61.5	309
7. I have often had a strong sense of God's presence. (E)	19.3	19.6	61.1	311
8. I pray mainly to gain relief and protection. (E)	40.8	13.3	46.0	309
9. I try to live all my life according to my religious beliefs. (I)	48.5	17.3	34.2	307
10. What religion offers me most is comfort in times of trouble and sorrow. (E)	39.0	13.3	47.7	308
11. My religion is important to me because it answers many questions about the meaning of life. (I)	44.4	19.6	35.9	306
12. I would rather join a Bible study group than a church social group. (I)	65.6	22.8	11.6	311
13. Prayer is for peace and happiness. (E)	23.3	12.6	64.1	309
14. Although I am religious, I don't let it affect my daily life. (E)	51.8	19.5	28.7	307
15. I go to church mostly to spend time with my friends. (E)	94.2	3.9	1.9	308
16. My whole approach to life is based on my religion. (I)	73.4	11.8	14.8	305
17. I go to church mainly because I enjoy seeing people I know there. (E)	88.6	4.9	6.5	307
18. I pray mainly because I have been taught to pray. (E)	65.2	11.6	23.2	310
19. Prayers I say when I am alone are as important to me as those I say in church. (I)	24.4	7.8	67.9	308
20. Although I believe in my religion, many other things are more important in life. (E)	26.3	24.4	49.4	308

(I) – Intrinsic Religiosity – 8 items (E) – Extrinsic Religiosity – 12 items

[8] Response categories for the item had the following values: 0-Never. 1-A few times a year, 2-Once every month or two, 3-Two or three times a month, 4-Once a week, and 5-More than once a week.

The Spirituality Well-Being Scale (Table 14) is composed of *intrinsic* spirituality and *existential* spirituality. The univariate analysis for intrinsic spirituality indicated that Latinos reported an overall positive experience with God as indicated by the following responses to items in the instrument: I don't find much satisfaction in prayer with God (approximately 71% disagreed to strongly disagreed); I believe that God loves me and cares about me (approximately 82% agreed to strongly agreed); I believe that God is impersonal and not interested in my daily situations (approximately 70% disagreed to strongly disagreed); I have a personally meaningful relationship with God (approximately 69% agreed to strongly agreed); I don't get much personal strength and support from my God (approximately 69% disagreed to strongly disagreed); I believe that God is concerned about my problems (approximately 70% agreed to strongly agreed); I don't have a personally satisfying relationship with God (approximately 65% disagreed to strongly disagreed); My relationship with God helps me not to feel lonely (approximately 65% agreed to strongly agreed); My relationship with God contributes to my sense of well-being (approximately 72% agreed to strongly agreed). The only intrinsic spirituality item that Latinos were divided on was: "I feel most fulfilled when I'm in close communion with God" (approximately 45% disagreed to strongly disagreed). The sample indicated that there is an overall connection with God, despite their overall preference to go to church (only 21.2% reported never going to church and 23.2% reported going to church a few times a year).

Latinos overall reported a positive sense of *existential spirituality* for the following items: I don't know who I am, where I come from, or where I am going (approximately 79% disagreed to strongly disagreed); I feel that life is a positive

experience (approximately 93% agreed to strongly agreed); I feel very fulfilled and satisfied with my life (approximately 83% agreed to strongly agreed); I feel a sense of well-being about the direction my life is headed in (approximately 87% agreed to strongly agreed); I don't enjoy much about my life (approximately 85% disagreed to strongly disagreed); I feel good about my future (approximately 90% agreed to strongly agreed); I feel that life is full of conflict and unhappiness (approximately 63% disagreed to strongly disagreed); Life doesn't have much meaning (approximately 85% disagreed to strongly disagreed); and I believe that there is some real purpose for my life (approximately 97% agreed to strongly agreed). Latinos in the study were divided on the following existential spirituality item: "I feel unsettled about my future" (approximately 59% disagreed to strongly disagreed).

Table 14: Participant responses to the Spirituality Well-Being Scale

Items	Scale (%)[9]						N
	1	2	3	4	5	6	
1. I don't find much satisfaction in private prayer with God. (I)	37.4	8.1	26.1	11.6	6.1	10.6	310
2. I don't know who I am, where I come from, or where I am going. (E)	44.2	11.3	24.2	10.0	3.2	7.1	310
3. I believe that God loves me and cares about me. (I)	6.8	2.9	6.8	28.7	10.3	44.5	310
4. I feel that life is a positive experience. (E)	2.3	1.0	2.9	35.0	17.8	41.1	309
5. I believe that God is impersonal and not interested in my daily situations. (I)	37.1	9.8	23.8	15.3	3.9	10.1	307
6. I feel unsettled about my future. (E)	20.3	14.5	24.8	22.3	11.0	7.1	310
7. I have a personally meaningful relationship with God. (I)	8.8	6.5	15.3	33.6	15.3	20.5	307
8. I feel very fulfilled and satisfied with life.(E)	2.3	4.2	10.4	36.6	24.6	22.0	309
9. I don't get much personal strength and support from my God. (I)	33.7	5.5	30.1	17.5	4.9	8.4	309
10. I feel a sense of well-being about the direction my life is headed in. (E)	3.2	2.9	6.5	43.7	16.2	27.5	309
11. I believe that God is concerned about my problems. (I)	8.4	4.9	15.6	33.8	9.7	27.6	308
12. I don't enjoy much about life. (E)	49.7	10.6	25.8	5.5	2.9	5.5	310
13. I don't have a personally satisfying relationship with God. (I)	28.2	9.4	27.6	17.9	6.8	10.1	308
14. I feel good about my future. (E)	2.3	2.6	4.6	41.7	21.8	27.0	307
15. My relationship with God helps me not to feel lonely. (I)	10.7	4.9	19.2	34.7	11.4	19.2	308
16. I feel that life is full of conflict and unhappiness. (E)	16.6	13.0	34.1	20.5	10.1	5.8	308
17. I feel most fulfilled when I'm in close communion with God. (I)	12.9	6.8	26.1	27.7	10.0	16.5	310
18. Life doesn't have much meaning. (E)	51.8	10.0	23.3	5.5	1.6	7.8	308
19. My relation with God contributes to my sense of well-being. (I)	11.0	2.6	14.5	39.4	10.0	22.6	310
20. I believe there is some real purpose for my life. (E)	.6	1.0	1.6	32.4	9.7	54.7	309

(I) – Intrinsic Spirituality – 10 items (E) – Existential Spirituality – 10 items

[9] Response categories for the items had the following values: 1-Strongly Disagree, 2-Moderately Disagree, 3-Disagree, 4-Agree, 5-Moderately Agree, and 6-Strongly Agree.

The univariate analyses for HIV knowledge (Table 15) revealed that the majority of the sample is knowledgeable of HIV transmission. The main inaccuracies of HIV transmission were for kissing (29.7%), breast feeding (21.4%), and sharing eating utensils (13.2%) with someone who is HIV positive. Other misconceptions among the sample were that: diaphragms are an effective way to reduce HIV transmission (16.3%); spermicidal jelly, foam, and cream are effective in reducing HIV transmission (14.6%); and condoms are unlikely to effectively reduce HIV transmission (11.3%). Latinos (11.6%) also believed that there is a vaccine that prevents HIV transmission.

Table 15: Participant responses on the HIV/AIDS Knowledge Scale

Items	False (%)	True (%)	N
1. HIV can reduce the body's natural protection against disease.	12.8	87.2	312
2. AIDS is an infectious disease caused by a virus.	5.8	94.2	312
3. There is no cure for AIDS at present.	7.1	92.9	311
4. A person that has the HIV virus can look and feel healthy and well.	3.5	96.5	310
5. There is a vaccine available to the public that protects a person from getting HIV.	88.4	11.6	310
6. A person can be infected with HIV and not have the disease AIDS.	7.4	92.6	311
7. Any person with HIV can pass it on to someone else during sexual intercourse without a condom.	.6	99.4	309
8. A pregnant woman who has HIV can give the virus to her baby.	5.8	94.2	311
9. Condoms are an effective means of reducing HIV transmission.	11.3	88.7	309
10. Spermicidal jelly, foam, and cream are effective in reducing HIV Transmission.	85.4	14.6	309
11. A diaphragm is an effective means of reducing HIV transmission.	83.3	16.3	311
How likely do you think that a person will get HIV from the following:	**Likely (%)**	**Unlikely (%)**	**N**
12. Shaking hands, touching or kissing on the cheek with someone who has HIV?	1.6	98.1	311
13. Kissing – with exchange of saliva – a person who has HIV?	29.7	70.3	310
14. Being coughed or sneezed on by someone who has HIV?	6.4	93.6	311
15. Sharing plates, forks, or glasses with someone who has HIV?	13.2	86.8	310
16. Eating in a restaurant where the cook has HIV?	10.1	89.9	307
17. Engaging in anal sex without a condom?	96.1	3.9	309
18. Sharing needles for drug use with someone who has HIV?	97.4	2.6	310
19. Using public toilets?	7.8	92.2	308
20. Being fed breast milk from a mother with HIV?	78.6	21.4	309

Respondents' attitudes toward PLWHA (Table 16) were positive. The Attitudes Towards PLWHA scale was composed of a subscale for *empathy towards PLWHA* and *avoidance towards PLWHA*. Latinos had high levels of empathy towards PLWHA as the following items indicate: I think patients with AIDS have the right to the same quality of care as any other patient (76.2% strongly agree); it is especially important for hospital patients with AIDS to be treated in a caring manner (65.8% strongly agree); a homosexual hospital patient's partner should be accorded the same respect and courtesy as the partner of a heterosexual patient (73.2% strongly agree); hospital patients with AIDS should be treated with the same respect as any other patient (74.6% strongly agree); I am sympathetic toward the misery people with AIDS experience (approximately 90% strongly agree to agree); I would like to do something to make life easier for people with AIDS (approximately 93% strongly agree to agree); and I would do everything I could to support people with AIDS (approximately 88% strongly agree to agree).

Latinos overall had low levels of avoidance for PLWHA as indicated in the following items (Table 16): most people who have AIDS have only themselves to blame (approximately 88% disagree to strongly disagree); most people who have AIDS deserve what they get (72.8% strongly disagree); hospital patients who are HIV positive should not be put in rooms with other patients (approximately 78% disagree to strongly disagree); if I had to have contact with someone with AIDS, I would worry about putting my family and friends at risk (approximately 78% disagree to strongly disagree); young children should be removed from the home if one of the parents is HIV positive (approximately 90% disagree to strongly disagree); I think people who are injection drug users deserve to get AIDS (62.7% strongly disagree); I think women who give birth to

babies who are HIV positive should be prosecuted for child abuse (approximately 90% disagree to strongly disagree); homosexuality should be illegal (75.8% strongly disagree); if I found out that a friend of mine was a homosexual, I would not maintain the friendship (82.3% strongly disagree); I'm worried about getting AIDS from social contact with someone (approximately 95% strongly disagree to disagree); children or people who get AIDS from blood transfusions are more deserving of treatment than those who get it from injection drug use (approximately 72% disagree to strongly disagree); I would be worried about my child getting AIDS if I knew that one of his teachers was a homosexual (71.6% strongly disagree); and I have little sympathy for people who get AIDS from sexual promiscuity (approximately 85% disagree to strongly disagree). Latinos were split (approximately 52% disagree to strongly disagree) in the study for the following item: "I feel more sympathetic towards people who get AIDS from blood transfusions than those who get it from injection drug use."

Table 16: Participant responses to the AIDS Attitudes Scale—Generic Version

Items	Scale (%)[10]						N
	1	2	3	4	5	6	
1. Most people who have AIDS have only themselves to blame. (A)	45.2	12.8	30.4	5.1	4.2	2.2	312
2. Most people who have AIDS deserve what they get. (A)	72.8	8.0	17.0	1.0	1.0	.3	312
3. Hospital patients who are HIV positive should not be put in rooms with other patients. (A)	43.7	11.9	23.2	14.1	4.5	2.6	311
4. If I had to have contact with someone with AIDS, I would worry about putting my family and friends at risk. (A)	40.8	9.1	28.2	13.9	3.6	4.5	309
5. Young children should be removed from the home if one of the parents is HIV positive. (A)	62.5	7.5	27.4	1.6	1.0	0	307
6. I think patients with AIDS have the right to the same quality of care as any other patient. (E)	2.6	0	.6	17.7	2.9	76.2	311
7. It is especially important for hospital patients with AIDS to be treated in a caring manner. (E)	2.6	1.0	1.9	23.2	5.5	65.8	310
8. I think people who are injection drug users deserve to get AIDS. (A)	62.7	7.1	27.3	2.3	.3	.3	311
9. I think women who give birth to babies who are HIV positive should be prosecuted for child abuse. (A)	54.7	10.0	28.2	4.2	2.3	.6	309
10. Homosexuality should be illegal. (A)	75.8	1.9	16.5	4.2	.3	1.3	310
11. I feel more sympathetic toward people who get AIDS from blood transfusions than those who get it form injection drug abuse. (A)	26.9	7.7	17.9	24.7	12.5	10.3	312
12. A homosexual hospital patient's partner should be accorded the same respect and courtesy as the partner of a heterosexual patient. (E)	1.9	0	1.3	21.0	2.6	73.2	310
13. Hospital patients with AIDS should be treated with the same respect as any other patient. (E)	1.9	.3	.6	22.2	.3	74.6	311
14. If I found out that a friend of mine was a homosexual, I would not maintain the friendship. (A)	82.3	2.3	10.3	1.6	.6	2.9	311
15. I'm worried about getting AIDS from social contact with someone. (A)	69.9	5.8	20.7	1.9	.3	1.3	309
16. I am sympathetic toward the misery people with AIDS experience. (E)	4.5	1.0	4.2	34.8	10.0	45.5	310
17. I would like to do something to make life easier for people with AIDS.(E)	1.0	.3	5.8	38.5	14.9	39.5	309
18. I would do everything I could to support people with AIDS. (E)	1.0	1.0	9.6	38.6	14.1	35.7	311
19. Children or people who get AIDS from blood transfusions are more deserving of treatment than those who get it from injection drug abuse. (A)	42.4	6.1	23.6	13.3	8.4	6.1	309
20. I would be worried about my child getting AIDS if I knew that one of his teachers was a homosexual. (A)	71.6	3.9	17.7	4.2	1.6	1.0	310
21. I have little sympathy for people who get AIDS from sexual promiscuity. (A)	45.5	13.8	25.6	10.3	3.2	1.6	312

(A) – HIV Avoidance – 14 items (E) – HIV Empathy – 7 items

[10] Response categories for the items had the following values: 1-Strongly Disagree, 2-Moderately Disagree, 3-Disagree, 4-Agree, 5-Moderately Agree, and 6-Strongly Agree.

Latinos expressed mostly positive *attitudes towards homosexuals* (Table 17) for the following items: I won't associate with known homosexuals if I can help it (77.7% strongly disagreed); the sight of two men kissing does NOT particularly bother me (approximately 72% agree to strongly agree); if two homosexuals want to get married, the law should let them (approximately 74% agree to strongly agree); homosexuals should be locked up to protect society (81.7% strongly disagree); homosexuals should never be given positions to trust in caring for children (73.1% strongly disagree); I would join an organization even though I knew it had homosexuals in its membership (61.8% strongly agree); in many ways, the AIDS disease currently killing homosexuals is just what they deserve (79.9% strongly disagree); homosexuality is "an abomination in the sight of God" (63.4% strongly disagree); homosexuals have the perfect right to their lifestyle, if that's the way they want to live (62.5% strongly agree); homosexuals should be forced to take whatever treatments science can come up with to make them normal (79.1% strongly disagree); people should feel sympathetic and understanding of homosexuals, who are unfairly attacked in our society (approximately 84% agree to strongly agree); and I wouldn't mind being seen smiling and chatting with a homosexual (66.2% strongly agreed).

Table 17: Participant responses to the Attitudes Toward Homosexuals Scale

Items	Scale (%)[11]						N
	1	2	3	4	5	6	
1. I won't associate with known homosexuals if I can help it.	77.7	2.6	15.5	2.3	.6	1.3	310
2. The sight of two men kissing does NOT particularly bother me.	11.0	3.5	13.5	26.8	9.0	36.1	310
3. If two homosexuals want to get married, the law should let them.	10.0	1.6	11.3	19.4	3.9	53.9	310
4. Homosexuals should be locked up to protect society.	81.7	1.0	15.8	.6	0	1.0	311
5. Homosexuals should never be given positions of trust in caring for children.	73.1	4.2	18.8	1.6	1.6	.6	309
6. I would join an organization even though I knew it had homosexuals in its membership.	8.4	.6	4.9	19.7	4.5	61.8	309
7. In many ways, the AIDS disease currently killing homosexuals is just what they deserve.	79.9	2.3	16.2	.6	.3	.6	308
8. Homosexuality is "an abomination in the sight of God."	63.4	2.3	18.1	9.1	1.6	5.5	309
9. Homosexuals have a perfect right to their lifestyle, if that's the way they want to live.	9.1	1.0	4.9	18.6	3.9	62.5	307
10. Homosexuals should be forced to take whatever treatments science can come up with to make them normal.	79.1	1.9	15.8	2.3	.3	.6	311
11. People should feel sympathetic and understanding of homosexuals, who are unfairly attacked in our society.	5.2	2.9	7.8	22.0	5.2	57.0	309
12. I wouldn't mind being seen smiling and chatting with a known homosexual.	8.4	1.0	6.4	14.8	3.2	66.2	311

[11] Response categories for the items had the following values: 1-Strongly Disagree, 2-Moderately Disagree, 3-Disagree, 4-Agree, 5-Moderately Agree, and 6-Strongly Agree.

8.3. ***Bivariate and Multiple Regression Analyses***

Bivariate analyses were conducted to explore if there were any significant relationships between the following variables : 1) Acculturation; 2) Religiosity; 3) Spiritual Well-Being (SWB); 4) Education (educational attainment); 5) Household income; 6) Age; 7) Gender_attitude (traditional gender-related attitudes); 8) HIV_Know (knowledge of HIV/AIDS); 9) HIV_Attitude (attitudes towards PLWHA); and 10) and HOMO_Attitude (attitudes towards homosexuals). Spirituality was not included in the original three hypotheses, but it was included in the analyses to distinguish it from religiosity and identify whether or not any significant associations existed with the outcome variables. Spirituality was categorized as an intervening variable. The following section will give an in depth review of the bivariate relationships and multivariate analyses for each outcome variable: knowledge of HIV/AIDS, attitudes towards PLWHA, and attitudes towards homosexuals. A multiple linear regression analysis (method: Enter) was selected to determine the relationship between outcome variables and multiple predictor and intervening variables. R squared was also selected for each multiple linear regression analysis to determine the proportion of variance accounted for the predictors in the model.

The overall premise of the first hypothesis was to explore the influence acculturation, religiosity, and gender-related beliefs have on knowledge of HIV/AIDS among Latinos. A multivariate analysis was conducted to assess the relationships between the predictor variables (i.e., educational attainment, household income, age), intervening variables (i.e., acculturation, religiosity, spirituality, gender-related attitudes),

and the outcome variables (i.e., knowledge of HIV/AIDS, attitudes towards PLWHA, attitudes towards homosexuals).

The zero-order correlations (Appendix F) indicated that acculturation, educational attainment, and household income positively predicted knowledge of HIV/AIDS. The following variables did not have a statistically significant relationship with knowledge of HIV/AIDS: religiosity, spirituality, age, and gender-related attitudes. Overall, the direction of the correlations was as expected for most of the variables. People that reported greater levels of acculturation, educational attainment, and household income were more likely to be knowledgeable of HIV/AIDS. People that reported greater levels of religiosity, spirituality, age, and traditional gender-related attitudes were less likely to be knowledgeable of HIV/AIDS. Although household income had a significant bivariate relationship ($p = .01$) with knowledge of HIV/AIDS (Appendix F), it did not account for unique variance after controlling for acculturation and educational attainment (Table 18). A multiple regression analysis (Table 18) was conducted on significant bivariate correlations to test for the unique contributions of each predictor simultaneously. The results indicated that educational attainment uniquely predicted knowledge of HIV/AIDS, $\beta = .22$, $t(266) = 3.45$, $p < .05$. The results also indicated that acculturation uniquely predicted knowledge of HIV/AIDS, $\beta = .15$, $t(266) = 2.40$, $p < .05$. The study found that Latinos that reported greater levels of educational attainment and acculturation were more likely to be knowledgeable of HIV/AIDS. The overall model (Table 18) indicated that educational attainment and acculturation accounted for 11% of the variance in knowledge of HIV/AIDS: $R^2 = .11$, $F(3, 266) = 10.68$, $p<.001$.

Table 18: Predictors of participants' HIV Knowledge

Predictors	B	*SE*	*β*	*t*	*p*
Acculturation	0.03	0.01	0.15	2.40	0.02
Educational Attainment	0.21	0.06	0.22	3.45	0.01
Household Income	0.05	0.04	0.07	1.06	0.29

Note: $R^2 = .11$, $F(3, 266) = 10.68$, $p<.001$

These findings indicate that for every unit increase in educational attainment and acculturation, knowledge of HIV increased. The hypothesis for knowledge of HIV/AIDS was therefore, accepted for acculturation ($p < .05$) and educational attainment ($p <.05$) but rejected for household income, religiosity, spirituality, age and traditional gender-related attitudes. The relationships of the latter variables to the outcome variable were however in the expected direction, and may have reached statistical significance with a larger sample size. For the current study however, only acculturation and educational attainment were found to significantly predict knowledge of HIV/AIDS.

The second hypothesis explored the influence that acculturation, religiosity, and gender-related beliefs have on attitudes towards PLWHA. A multivariate analysis was conducted to assess the relationships between the predictor variables (i.e., educational attainment, household income, age), intervening variables (i.e., acculturation, religiosity, spirituality, gender-related attitudes), and the outcome variable attitudes towards PLWHA.

The zero-order correlations (Appendix G) indicated that religiosity and gender-related attitudes predicted attitudes towards PLWHA. The following variables did not have a significant association with attitudes towards PLWHA: acculturation, spirituality, educational attainment, household income, and age. Overall, the direction of the

correlations was as expected, but acculturation was the exception and it was positively correlated, albeit very low, with attitudes towards PLWHA. Acculturation, religiosity, spirituality, and traditional gender-related attitudes were found to be positively correlated with attitudes towards PLWHA; Latinos that reported greater levels of acculturation, religiosity, spirituality, and traditional gender-related attitudes were more likely to have negative attitudes towards PLWHA. Educational attainment, household income, and age were found to be negatively correlated with attitudes towards PLWHA; Latinos that reported greater levels of educational attainment, household income, and age were less likely to have negative attitudes towards homosexuals. A multiple regression analysis (Table 19) was conducted on significant bivariate correlations to test for the unique contributions of each predictor simultaneously. The results indicated that gender-related attitudes uniquely predicted attitudes towards PLWHA, $\beta = .26$, $t(247) = 4.08$, $p < .05$. For every unit increase in traditional gender-related attitudes, negative attitudes towards PLWHA increased. Although religiosity had a significant bivariate relationship with attitudes towards PLWHA, it did not account for unique variance after controlling for gender-related attitudes. The overall model , indicated that traditional gender-related attitudes accounted for 9% of variance in attitudes towards PLWHA, $R^2 = .09$, $F(2, 247) = 11.73$, $p<.001$.

Table 19: Predictors of Attitudes towards PLWHA

Predictors	**B**	***SE***	***β***	***t***	***P***
Religiosity	0.11	0.08	0.09	1.46	0.15
Gender Attitude	0.30	0.08	0.26	4.08	0.00

Note: $R^2 = .09$, $F(2, 247) = 11.73$, $p<.001$

The hypothesis for attitudes towards PLWHA was accepted for traditional gender-related attitudes, but rejected for acculturation, educational attainment, and religiosity.

The third hypothesis explored the influence educational attainment, household income, and age; mediated by acculturation, religiosity, spirituality, and gender-related beliefs have on attitudes towards homosexuals. A multivariate analysis was conducted to assess the relationships between the predictor variables (i.e., educational attainment, household income, age), intervening variables (i.e. acculturation, religiosity, spirituality, gender-related attitudes,), and the outcome variable attitudes towards homosexuals.

The zero-order correlations (Appendix H) indicated that acculturation, religiosity, educational attainment, gender-related attitudes, and age predicted attitudes towards homosexuals. Spirituality and household income were not significantly associated with attitudes towards homosexuals. Overall, the direction of the correlations was as expected and showed that attitudes towards homosexuals was negatively correlated with acculturation and educational attainment. Religiosity, age and traditional gender-related attitudes were found to be positively correlated with attitudes towards homosexuals; Latinos that reported greater levels of religiosity, age, and traditional gender–related attitudes were more likely to have negative attitudes towards homosexuals. Acculturation, spirituality, educational attainment, and household income were found to be negatively correlated with attitudes towards homosexuals; Latinos that reported greater levels of acculturation, spirituality, educational attainment, and household income were less likely to have negative attitudes towards homosexuals. A multiple regression analysis (Table 20) was conducted on significant bivariate correlations to test for the unique contributions of each predictor simultaneously. The results indicated that

acculturation uniquely predicted attitudes towards homosexuals, β = -.12, $t(236) = -1.99$, $p = .05$. For every unit increase in acculturation, negative attitudes towards homosexuals decreased. The results also indicated that educational attainment uniquely predicted attitudes towards homosexuals, β = -.12, $t(236) = -2.03$, $p < .05$. For every unit increase in educational attainment, negative attitudes towards homosexuals also decreased. The results indicated that traditional gender-related attitudes uniquely predicted attitudes towards homosexuals: β = .30, $t(236) = 4.89$, $p < .05$. People that reported greater levels of traditional gender-related attitudes were more likely to have negative attitudes towards homosexuals. The results indicated that age uniquely predicted attitudes towards homosexuals, β = .23, $t(236) = 4.02$, $p < .05$. People that reported an older age were more likely to have negative attitudes towards homosexuals. Although religiosity had a significant ($p<.05$) bivariate relationship with attitudes towards homosexuals, it did not account for unique variance after controlling for acculturation, educational attainment, gender-related attitudes, and age. The overall model indicated that acculturation, educational attainment, age, and traditional gender-related attitudes accounted for 23% of the variance in attitudes towards homosexuals, $R^2 = .23$, $F(5, 236) = 13.58$, $p<.001$.

Table 20: Predictors of Attitudes towards Homosexuals

Predictors	**B**	***SE***	***β***	***t***	***p***
Acculturation	-0.17	0.09	-0.12	-1.99	0.05
Religiosity	0.15	0.09	0.11	1.75	0.08
Educational Attainment	-0.74	0.36	-0.12	-2.03	0.04
Age	0.27	0.07	0.23	4.02	0.00
Gender Attitude	0.43	0.09	0.30	4.89	0.00

Note: $R^2 = .23$, $F(5, 236) = 13.58$, $p<.001$

The hypothesis for attitudes towards homosexuals was rejected for religiosity, but the correlation came close to being statistically significant (p = .08). With a larger sample size, the relationship may have been statistically significant.

9. Discussion

The Univariate Analyses: The present research study explored the influence religiosity, traditional gender-related attitudes, and acculturation have on knowledge of HIV/AIDS, attitudes towards PLWHA, and attitudes towards homosexuals among the general Latino population. A focus on the general Latino population is important because it places an emphasis on people in the community who reinforce social structures that promote inequality and stigmas among marginalized populations (e.g., MSM, PLWHA). The sample was made up of predominantly heterosexual females, highly educated, highly acculturated, and who reported low levels of religiosity. The findings shed insight on critical nuances within the Latino community and the HIV/AIDS epidemic in the U.S.

Acculturation: The results of the acculturation scale reinforce findings from prior research studies on significant associations between acculturation and knowledge of HIV/AIDS among Latinos. Latinos who reported lower levels of acculturation also reported lower levels of HIV/AIDS knowledge (Bianchi, et al. 2004; Marin & Marin 1990; Miller, Guarnaccia, & Fasina, 2002). The utilization of language sheds insight on how to tailor culturally appropriate interventions addressing health disparities among Latinos and reinforces a bilingual approach for the dissemination of resources and provision of services for this target population. Media use for television and radio was more skewed towards English, but greater levels of education also reinforce one's aptitude to utilize media that is predominantly English. A preference for Latinos to socialize with other Latinos stresses the need for culturally appropriate interventions to be available in Spanish, but also the availability of Latino providers to work at various levels (e.g., peer educators, outreach workers, case managers, researchers) with the community.

Marianismo and machismo (traditional gender-related attitudes) stereotypes challenged: Future studies should look at the stereotypes of historically oppressed and highly marginalized populations and the implications these stereotypes can have on programs addressing HIV/AIDS. Researchers (Bull, 1998; Singer, 1990; Sternberg, 2000; Wood & Price, 1997) have emphasized how Latino men have been stigmatized as being hyper-masculine (i.e., *machismo*). HIV interventions that reinforce racial stigmas among Latinos (e.g., *machismo, marianismo*) create a condescending environment, which make it difficult for services to appropriately address the needs of the Latino community and the implications these stereotypes can have on treatment programs.

HIV interventions should take a client centered empowering approach towards enhancing risk reduction among Latina females. The majority of the respondents were highly educated females who disagreed with Latina women reinforcing traits associated with *marianismo*, but they were split in agreeing that it is the man's job to protect the family. The finding indicates that the role of Latino males also should be respected and not demonized as a result of *machismo*. Professionals (e.g., researchers, service providers, professors) should avoid reinforcing racial stereotypes for Latinos as expressed in the literature review for *marianismo* and *machismo* and initiatives should address masculine and feminine personal traits regardless of race and/or ethnicity that apply to both males and females.

Intrinsic Religiosity: The *intrinsic religiosity* items demonstrate the complex nuances of religiosity and the influence it has on one's beliefs and values. The results indicate that religious beliefs and values can be expressed in an organized religious setting as well as

independent of religious institutions. Faith-based initiatives addressing HIV/AIDS in religious communities encounter obstacles in addressing behaviors (e.g., sex before marriage, promiscuity, homosexual behavior, substance use, condom use) within a framework that reinforces religious beliefs and values. Religious rhetoric must reinforce the acceptance of highly marginalized populations such as MSM, PLWHA, IDU, and CSW. HIV/AIDS providers are encouraged to collaborate with religious leaders to identify passages in the Bible that would strengthen efforts towards addressing the needs of members in the community that are at greater risk of HIV/AIDS.

***Extrinsic religiosity*:** The items for extrinsic religiosity demonstrated that the social component (e.g., meeting with friends, making new friends) of religion is limited among Latinos participants and despite what other people believe Latinos did not ignore their religious beliefs. Catholicism has been perceived as a conservative religious practice, which has provided Christian Evangelicals with the opportunity to gain members through a more engaging approach of worship. The Evangelical movement in Guatemala demonstrates how they have encouraged Catholics to convert by creating a socially engaging environment of singing and dancing during worship. Evangelicals also place a strong emphasis on creating social enclaves (religious communities) to reinforce a sense of belonging and preaching the gospel (Stoll, 1994). Faith-based initiatives addressing HIV/AIDS through religious communities should take an empowering approach and tailor initiatives to fit the community and not vice versa. HIV/AIDS providers are encouraged to conduct an assessment to identify the strengths and obstacles in

collaborating with religious communities. Faith-based initiatives should capitalize on the strengths of a religious community.

Intrinsic Spirituality: The data indicate that spirituality has some meaning for Latinos despite frequency of religious attendance. Faith-based interventions addressing HIV among Latinos should focus on spirituality as a source of resiliency. Levels of religiosity were strongly associated with spirituality, but the findings also indicate that high levels of spirituality do not necessarily determine regular attendance at a religious institution. García and colleagues (2008) also indicated that religion was synonymous with being Latino. Therefore, despite levels of low religious attendance the findings indicate that the family can play a critical role in reinforcing religious beliefs outside of the church. Faith-based initiatives addressing HIV in the Latino community should develop a family based approach that integrates religious beliefs towards addressing HIV/AIDS. A special emphasis can be placed on helping families create an environment free of discrimination against highly marginalized populations such as homosexuals and PLWHA. The theoretical section can provide a foundation on how social stratification is reinforced within historically oppressed populations and the implications for increasing susceptibility to social disparities within the community. The social campaign "We all have AIDS if one of us does" created by Kenneth Cole places an emphasis on utilizing the power and status of celebrities to de-stigmatize HIV in the community. A similar approach can be taken fin the religious community as well as historically oppressed communities to prevent PLWHA from being ostracized and reinforce a compassionate response to a social problem. Cotton and colleagues (2006) found that spirituality

provided a critical source of support for PLWHA and helped them cope with their HIV status. The present study also indicated that levels of spirituality were significantly associated with religiosity.

Existential Spirituality: Many Latinos felt unsettled about their future, which is understandable due to the fragile state of the economy and the fact that educational attainment no longer guarantees a well paying job. Social determinants associated with educational attainment, housing status, and employment status are all interrelated and can make preexisting health conditions worse, which heightens one's susceptibility to social disparities. People in desperate situations (e.g., unemployed, uninsured, homeless) shift their focus from long-term goals (e.g., long healthy sustainable future) to short-term goals focused on meeting their immediate basic needs, which can hinder one's existential spiritual development. Inequality reinforced by social structures can also hinder one from fully developing personal characteristics (e.g., intelligence, conscience, spirituality) as a human being regardless of race, sex, religion, political and/or other opinion (OHCHR, 2011). An emphasis on the UDHR provides a framework for multiple agencies to address human rights violations among historically oppressed and highly marginalized populations. A sense of existential well-being is a source of resilience and an influential resource for individual's to reduce their exposure to HIV/AIDS. Existential spirituality also does not take into account one's beliefs about God and places a greater emphasis on the trajectory for one's life.

HIV Knowledge: The results of the survey demonstrate a greater need for public health initiatives to educate the Latino community on the modes of HIV transmission, which would strengthen initiatives to decrease levels of discrimination against PLWHA. Inadequate knowledge about methods of HIV transmission is detrimental towards stopping the spread of HIV as well as preventing discrimination against PLWHA. Misconceptions of HIV transmission may cause people to modify their behavior around PLWHA. People that believe HIV is transmitted through saliva might prevent PLWHA from using the same eating utensils. Latinos regard their families as an integral part of their social life and a source of support. An HIV diagnosis of an immediate family member may cause a major disruption of PLWHA if one's family is afraid of catching HIV through daily activities (e.g., cooking, using the bathroom, child care). For example a parent may worry about his/her child being infected with HIV if a person resides, plays, and/or cares for a child. Stigmas and misconceptions associated with HIV/AIDS may prevent PLWHA from disclosing their status to their family, support system, and/or sexual partners. Fear of rejection may cause newly infected people to isolate themselves and deal with the burden on their own, which increases levels of stress and non-adherence to medical treatment (e.g., missed medical appointments, medication regimen). HIV interventions need to emphasize that HIV is transmitted through blood, semen, vaginal fluids, and breast milk. Providers must clarify that "[t]hese specific fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the blood-stream (from a needle or syringe) for transmission to possibly occur" (CDC, 2010).

Attitudes towards PLWHA: Overall negative attitudes towards PLWHA from the general Latino population provide critical insight on how social stratification is reinforced within historically oppressed populations. There was a significant negative correlation found between knowledge of HIV/AIDS transmission and negative attitudes towards PLWHA, which stresses the need for providers to educate Latinos on the modes of HIV transmission. Glassman and colleagues (2010) found that Mexican men were less likely to get tested if they perceived stigmatization of PLWHA. Providers are encouraged to develop interventions that prevent people from stigmatizing PLWHA and place a stronger emphasis on initiatives for the community to support people affected by HIV/AIDS. Public service announcements should use respected members in the community to raise awareness about HIV/AIDS. Latina women (i.e., mothers, grandmothers) play an influential role in reinforcing religiosity (Gillum & Holt, 2010) as well as caregivers for the family. They can also play a significant role in becoming peer educators in the community. An emphasis is placed on the community to resonate with the people in the campaigns that integrate ethnic and family pride. Campaigns should promote love and acceptance regardless of sexuality, gender, or HIV status. Promotion of HIV/AIDS awareness and education gives the target population the tools and information needed to reinforce HIV risk reduction and become a source of support for PLWHA. Research studies have shown that family values play an important role among Latinos. Including families when addressing the needs of historically oppressed and highly marginalized populations uses support systems that already in place. PLWHA are also more likely to disclose their status to their nuclear if family members have positive attitudes towards PLWHA.

Attitudes towards Homosexuals: Social stratification reinforces gender norms in the community and people that deviate from these norms are stigmatized. Males that have feminine gender traits are stigmatized as gay and ostracized. Homophobia can have detrimental effects on the community. The media has recently raised awareness of gay youth being bullied, which has caused some gay youth to commit suicide. *Machismo* further reinforces stigmas among Latinos and encourages gay males to act out idealized sexual scripts such as being sexually active and having multiple sex partners. Discrimination based on race as well as sexuality increases risks among a highly vulnerable population especially during adolescence. The literature review on sexual identity (Carrillo, 1999; Diaz & Ayala, 1999; Marsiglia, 1998; Roque-Ramirez, 2003; Williams et al., 2004; Wood & Price, 1997) emphasized the implications of fatalism and helplessness among a highly marginalized population within a historically oppressed group. Latinos in this study reported positive attitudes towards homosexuals, but the sample was primarily composed of highly educated females with low levels of religiosity. Despite the limitations of the sample the findings shed light on attitudes towards homosexuals. Approximately 84% believed (agreed to strongly agreed) that "homosexuals have the perfect right to their lifestyle…" and 98% did not believe (disagreed to strongly disagree) that "…the AIDS disease currently killing homosexuals is what they deserve." The question focused on attitudes towards homosexuals among their social network, but it would be interesting to explore attitudes of homosexuality within one's immediate family. For example one question could read, "I would not mind if my son is a homosexual?" People might feel differently about having someone who is

homosexual in their immediate family than in their social network. Openly out GLBT practitioners increase visibility in the community and provide role models for GLBT youth. Public service announcements can promote anti-stigma campaigns for HIV/AIDS as well as homosexuality, but campaigns should recruit male figures (e.g., fathers, grandfathers, heterosexual peers) in supporting the GLBT community. Initiatives such as Parents, Families, & Friends of Lesbian and Gays (PFLAG) play an instrumental role in providing a support network for families with GLBT youth.

The Bivariate Analyses: Many of the bivariate analyses revealed relationships between variables that were in the expected direction. However, greater levels of acculturation were expected to have positive correlations with levels of HIV/AIDS knowledge, but the study found negative correlations with attitudes towards PLWHA and homosexuals. Greater levels of acculturation indicate that the individual has been exposed to a more diverse network and the individual has taken strides towards acclimating to their environment. Acculturation had a significantly positive correlation with educational attainment. The acculturation process requires people to speak English, which diminishes obstacles towards accessing resources (e.g., employment, healthcare, social services) in comparison to Latinos in the U.S. that only speak Spanish. Therefore, Latinos that prefer a social network with only other Latinos would have less exposure to others that might challenge their traditional beliefs and values.

Anticipated correlations between religiosity and traditional gender-related attitudes were based on the principles of religious fundamentalism, which stigmatizes homosexuality and PLWHA. Religious fundamentalist and highly conservative religious

groups reinforce gender norms through a patriarchic structure. Females are perceived as inferior to the male and must cater to the needs of the family. A negative correlation was also expected between traditional gender-related attitudes and knowledge of HIV/AIDS due to faith-based initiatives reinforcing abstinence based programs, which avoids discussions about sexual behaviors and identity. People that report greater levels of traditional gender-related attitudes would be less likely to consider sources that do not reinforce their traditional beliefs and values. The bivariate correlations also indicated significant associations for traditional gender-related attitudes with lower levels of empathy for PLWHA and higher levels of avoiding PLWHA. Greater levels of traditional gender-related attitudes were significantly correlated with greater levels of negative attitudes towards homosexuals.

An emphasis was placed on religiosity to explore differences between intrinsic religiosity and extrinsic religiosity. Intrinsic and extrinsic religiosity only shared significant correlations with traditional gender-related attitudes and intrinsic spirituality. Intrinsic religiosity was significantly associated with spiritual well-being, negative attitudes towards PLWHA, lower knowledge of HIV/AIDS, and negative attitudes towards homosexuals. Extrinsic religiosity had significantly negative correlations with acculturation, existential spirituality, and empathy towards PLWHA. The negative correlation between extrinsic religiosity and existential spirituality was surprising, but requires further exploration among highly religious groups to gain greater insight on the association. The relationship implies that people with greater levels of extrinsic religiosity have lower levels of existential spirituality.

The Multivariate Analyses:

The first model was successful in predicting the direction of correlations for HIV/AIDS knowledge among Latinos, but only educational attainment and acculturation confirmed the hypothesis. They accounted for 11% of the variance and had significant positive correlations with HIV/AIDS knowledge. Religiosity and gender-related attitudes had a negative correlation with HIV/AIDS knowledge, but the direction of the correlations was as expected. A low representation from highly religious Latinos in the sample may have had an impact on the results, but it does provide some interesting information for future research initiatives. The findings for the first model imply that educational attainment and acculturation are significant predictors for Latinos to be more knowledgeable of HIV/AIDS. The findings shed insight into the influence social determinants has on increasing resilience among historically oppressed populations.

The second model was also successful in predicting the direction of correlations for HIV/AIDS knowledge among Latinos, but acculturation had a positive correlation with negative attitudes towards PLWHA. The anticipated direction of the correlation was that people who are more acculturated would be more likely to interact with a diverse social network, which would reinforce more liberal attitudes towards others. A counter argument that was not taken into consideration and requires further exploration is the role power and status plays in reinforcing a conservative ideology. Freire (1970) introduces the concept of historically oppressed people becoming greater tyrants and reinforcing inequality once they have acquired power and status. One possible explanation is that more acculturated Latinos may place a greater emphasis on one being held accountable

for his/her actions. They would insist that PLWHA are to blame for being infected with HIV/AIDS since PLWHA could have taken measures to reduce their risk of exposure to HIV transmission. The association is interesting and requires further investigation to determine the relationship between acculturation and attitudes towards PLWHA. The predictors for attitudes towards PLWHA showed a significant positive correlation for religiosity and traditional gender-related attitudes. Only traditional gender-related attitudes confirmed the hypothesis, accounting for 9% of the variance. The associations indicated that Latinos with lower levels of reinforcing traditional gender-related attitudes are less likely to have negative attitudes towards PLWHA. Support for the association is based on the literature as explained in the section for bivariate analyses.

The third model was successful in predicting the direction of correlations for attitudes towards homosexuals among Latinos; but only acculturation, educational attainment, age, and gender-related attitudes confirmed the hypothesis and accounted for 23% of the variance for attitudes towards homosexuals. Religiosity however was shy of becoming statistically significant ($p=.08$) for predicting attitudes towards homosexuals among Latinos. Acculturation and educational attainment were negatively correlated as predictors for attitudes towards homosexuals. The relationships imply that greater levels of acculturation and educational attainment would reduce negative attitudes towards homosexuals. Religiosity and gender-related attitudes were positively correlated with negative attitudes towards homosexuals. The relationships indicate that as levels of religiosity and gender-related attitudes increase negative attitudes towards homosexuals also increase.

The most unanticipated and interesting finding was for attitudes towards PLWHA (model 2) and homosexuals (model 3). The correlations indicated that more acculturated Latinos are more likely to have negative attitudes towards PLWHA and more likely to be accepting of homosexuals. Research is needed to emphasize the implications of acculturation and how it relates to reinforcing attitudes towards PLWHA and homosexuals.

Spiritual well-being did not have a significant association with knowledge of HIV/AIDS, attitudes towards PLWHA and homosexuals. The outcomes reveal that there are significant differences between religiosity and spirituality, which reinforces the need to differentiate between the two concepts and further explore implications for influencing behavior and beliefs for historically oppressed and highly marginalized populations.

Implications for Social Work Practice and HIV Prevention Interventions

This study explored the influence social stratification has on attitudes towards HIV/AIDS and homosexuality in the Latino community. The research findings support the theoretical framework that the power elite reinforce social stratification through social structures (i.e., religious institution). The conceptualization of religiosity and spirituality is critical to emphasize the influence of a social structure on a historically oppressed population. Spirituality was defined as one's intrinsic search for what is sacred as an individual or through a social structure such as a church (Hill & Pargament, 2003). Hill and Pargament (2003) conceptualized religiosity as a social structure that reinforces the search for the sacred as a group of people (intrinsic religiosity) and/or provides a sense of community (extrinsic religiosity). The instruments used to measure religiosity (Revised I-E Scale) and spirituality (SWBS) supported Hill and Pargament's model. The findings

in the present study reinforced the literature that religiosity and spirituality should not be used interchangeably and clear distinctions are essential in order to gain a better understanding of the phenomenon. No significant associations were found with spirituality and the other variables, but significant associations with religiosity demonstrated the influence religious institutions have on reinforcing beliefs and values in the community.

Faith-based initiatives have gained momentum in addressing social disparities among historically oppressed and highly marginalized populations. The American government's initiative to implement the Federal Centers for Faith-based and Community Initiatives has allocated funds for faith-based organizations, which prevents an open competitive process to designate funds to the best provider. The findings in this study indicated that greater levels of religiosity were associated with lower levels of HIV/AIDS knowledge, higher levels of negative attitudes towards PLWHA and homosexuals. Many faith-based organizations that receive funding for HIV prevention interventions provide an abstinence based initiative that avoids discussion of subjects (e.g., premarital sex, homosexuality, commercial sex work, substance use) that do not reinforce religious beliefs and values.

Faith-based initiatives should also integrate scriptures when addressing the needs of historically oppressed or marginalized communities (e.g., Latinos, MSM, PLWHA). A greater emphasis must be placed on acceptance and not judging others in order to create a loving community of support. Religious institutions also need to become leaders in guiding the community towards addressing obstacles and not wait for the community to request support for a problem that could have been prevented. The HIV/AIDS

epidemic is a perfect example were religious institutions did not respond because the problems were due to highly taboo issues (e.g., homosexuality, premarital sex, substance use, contraceptives) that did not reinforce religious ideology. Social workers can utilize instruments in this study to conduct needs assessments and assist religious leaders in developing services for the community. The data provides essential information that religious leaders should take into consideration in order to enhance services for their communities. The religiosity and spirituality scales can provide information on ways religious leaders can enhance religious services for the community. Professionals should collaborate with religious leaders in developing suitable HIV interventions that would integrate religious beliefs and values. Researchers should refrain from using religiosity and spirituality interchangeably and further conceptualize the distinction between religiosity and spirituality. Religious attendance does not determine levels of religiosity and prayer does not determine levels of spirituality.

Social workers can play in integral role towards enhancing faith-based initiatives addressing HIV/AIDS among historically oppressed and highly marginalized populations. An emphasis must be placed on the heterogeneity of the Latino population and provide a client centered approach for the community to share their lived experiences to guide initiatives. Professionals play an integral role in assessing the community's needs and developing initiatives that reflect social issues affecting the community while addressing the concerns of funders. Categorizing populations into generalized racial groups (e.g., Latinos) provides stakeholders with essential information towards addressing the needs of a designated target population, but professionals should take extra efforts to understand the ways in which nuances related to identity and culture

influence social disparities. For example, the present study demonstrated how levels of acculturation are significantly associated with religiosity, educational attainment, household income, knowledge of HIV/AIDS, and attitudes towards homosexuals. Based on these findings providers should recruit people from the target population as peer workers and integrate their cultural beliefs and values into the HIV prevention program. A community advisory board is also a great way to show the community that their knowledge is valuable asset. The process also provides an opportunity for the community to invest in the programs and gain a sense of ownership.

Individual interventions for Latinos should focus on modifying behavior and providing resources (e.g., support groups, culturally sensitive services, HIV testing and counseling) to buffer against negative environmental factors (e.g., homophobia, discrimination, xenophobia). The findings also indicated that despite the high levels of acculturation Latinos prefer that at least half of their social network be Latino, which implies the need to have Latino service providers in programs that target the Latino community. Populations from historically oppressed backgrounds feel slighted and exploited by the power elite who capitalize on their despair, which also reinforces the need for more researchers of color to conduct studies and develop services for their community.

Community-level interventions in the Latino community may "borrow" from the Brazilian experience and use some of the strategies to advocate for a change in existing beliefs and values that increase exposure to HIV transmission within the Latino community. Multiple social problems (e.g., unemployment, substance use, mental illness, homelessness, poverty) increase susceptibility to HIV infection. Social disparities

(e.g., HIV/AIDS, substance use, mental illness) are often interrelated and increase an individual's susceptibility to developing comorbidity of diseases and/or conditions, which is reinforced by society's support of social structures. An emphasis on the Universal Declaration of Human Rights allows multiple organizations with different causes (e.g., cancer, unemployment, homelessness) to collaborate on a shared vision of addressing social disparities and ensuring human rights initiatives for historically oppressed and highly marginalized populations. For example, an AIDS service organization can partner with another agency to assist immigrants in learning English as a second language and/or provide vocational training to increase employment opportunities for participants, which may gain them access to private health insurance.

Research initiatives place a significant focus on "at-risk" populations to gain a better understanding of how to prevent social disparities in the community, but researchers often fail to investigate the role that the power elite have in reinforcing inequality within as well as outside of historically oppressed and highly marginalized populations. Significant obstacles in addressing social disparities among historically oppressed populations are related to social structures reinforcing power and status. Researchers for example collect data from historically oppressed and highly marginalized populations, but fail to actively involve the community (e.g., participatory action research) or provide employment opportunities for the target population. A hierarchy is also reinforced within a research study that places an emphasis on power and status, which determines research initiatives from the top down. A greater emphasis must be placed on sustainable development for research initiatives with historically oppressed populations, such as looking at the lived experienced as opposed to educational

attainment and provide a living wage for staff employed from the target population. A greater emphasis must also be placed on social stratification within as well as outside of historically oppressed and highly marginalized populations. Inequality reinforces social stratification, which creates an environment for groups to compete with each other to distinguish between the "deserving" and "undeserving." For example, some highly marginalized populations from the white dominant population (i.e., power elite) fail to acknowledge their white privilege and declare that they too have suffered oppression based on their biological sex, sexuality, religious denomination, and/or age. Academics, practitioners, and researchers must develop a greater understanding on how social stratification and neocolonialism is reinforced and stop perpetuating the dysfunctional cycle of oppression.

Limitations of the Study

The length of the survey (approximately 30 minutes to complete) and lack of financial reimbursement for their time could have been a significant obstacle for participants responding to the study. The lottery was an attempt to provide a financial incentive for participating in the study, but the remuneration (if any) came much later in the study and participants might not have been motivated to wait for the lottery outcome.

Developing a survey that was self-administered on the internet provided greater flexibility for people to participate in the survey. Participants also had the option to save the survey at any time so they could return at their convenience and complete the remaining part of the survey. Another limitation for conducting an internet survey was that people needed to have access to a computer and the internet in order to participate in

the study, which is reflected by the high levels of educational attainment among the sample.

A convenience sample with its attendant biases was selected to recruit participants from colleges throughout the U.S. Disparities associated with educational attainment are reflected in the oversampling of Latinas. Latino males have significantly lower rates of college education, which place them at greater risk of exposure to HIV and other sexually transmitted infections. Therefore, generalizations to American Latinos overall is limited, but findings can assist academic institutions in preparing future professionals towards addressing the needs of the Latino community.

The limited number of highly religious participants in the sample may have influenced the outcomes for religiosity and traditional gender-related attitudes. Attempts were made to reach out to faith-based initiatives addressing HIV/AIDS in the Latino community, but the responses were limited.

The religiosity and spirituality scales are tailored for Christian religious groups, and researchers are encouraged to make minor changes for terms referencing religious institutions as well as churches, a higher-being instead of God, and religious text/scripture instead of Bible to take into consideration other religious groups. The scales for religiosity and spirituality should also provide a “not applicable” option for people that identify as agnostic or atheist. A few participants that identified as agnostic or atheist indicated that the questions about religiosity caused them to stop participating in the study. Participants had the option to skip questions, but the repeated items about religiosity and spirituality may have resulted in their avoiding this section of the survey completely.

Directions for Future Research

The present study was inspired by the lived experiences people have shared with me throughout my career as a service provider for PLWHA and the homosexual community of color. People from historically oppressed and highly marginalized populations were torn between their sexuality and/or HIV status and the implications in their respective communities. They were raised and deeply entrenched in their community, but struggles with their sexuality and health caused them to be directly and indirectly marginalized by their community. The discrimination that the males encountered resulted in a sense of guilt and shame for having homosexual encounters and/or being infected with HIV. Many HIV interventions focused on the MSM community as the source of the problem for spreading the HIV epidemic, but there was a significant gap in the literature exploring the roles social structures have in reinforcing inequality among historically oppressed and highly marginalized populations.

Inequality is not limited to white and black, greater initiatives must be taken to determine how social stratification is reinforced by the power elite as well as within historically oppressed and highly marginalized populations. The findings of this study indicated that greater levels of religiosity among Latinos were significantly correlated with lower levels of acculturation, greater levels of traditional gender-related attitudes, greater levels of spiritual well-being, lower levels of educational attainment, greater negative attitudes towards PLWHA, and greater negative attitudes towards homosexuals. Spiritual well-being was only significantly correlated (positively) with religiosity and household income. Greater research needs to explore the influence religiosity and spirituality have in society. Religiosity involves more than attending religious sermons

and professionals should take into account the role religious institutions provide the community in their search for the sacred (intrinsic religiosity) as well as developing a sense of community (extrinsic religiosity). Professionals must also refrain from exhibiting personal bias and not assume that all religious services benefit the community.

The HIV/AIDS pandemic has reached three decades and has had a disproportionate impact on populations that are historically oppressed, highly marginalized, and poverty stricken. The literature demonstrates that avoiding the problem fuels the spread of HIV and places a greater burden on societies. Open discussion of sex does not cause youth to become sexually active at an earlier age and distribution of condoms does not encourage people to have sex. Education on the modes of HIV transmission is critical for people to make informed decisions. The availability of condoms allows people to take protective measures to reduce their risk of HIV transmission. Latinos in the research study have also reported some inaccuracies related to HIV transmission, for example the belief that kissing (29.7%), breast feeding (21.4%), and sharing eating utensils (13.2%) with someone who is HIV positive can lead to HIV transmission. Additional misconceptions were that: diaphragms are an effective way to reduce HIV transmission (16.3%); spermicidal jelly, foam, and cream are effective in reducing HIV transmission (14.6%); and condoms are unlikely to effectively reduce HIV transmission (11.3%). Latinos (11.6%) also believed that there is a vaccine that prevents HIV transmission.

Knowledge of HIV/AIDS was found to have a significant negative correlation with negative attitudes towards PLWHA and homosexuals, which meant that the more people knew about HIV transmission the less likely they would have negative attitudes

towards PLWHA and homosexuals. Greater knowledge of HIV/AIDS in the general population provides a greater amount of understanding and support for PLWHA. People are more likely to get tested for HIV if they: understand the effects of HIV on the body (e.g., viral load, T-cell count), have access to affordable healthcare (e.g., medical treatment, medications), and are not ostracized for being HIV positive. HIV is no longer considered a fatal disease and it has transitioned into a chronic disease, which requires continued access to medical care and medications. HIV interventions that encourage HIV serosorting have the best intentions in reducing HIV transmission by encouraging HIV negative people to only have sex with other HIV negative people and HIV positive people to only have sex with other HIV positive people, but serosorting reinforces discrimination and stigmas among HIV positive people. The backlash of serosorting is that people that are HIV positive may not disclose their status due to being rejected by HIV negative sex partners and/or people may decide not to use condoms if they have the same HIV status.

An emphasis is placed on social structures and how the power elite conceptualize a social problem (e.g., HIV/AIDS) and address it among general society, which includes access to affordable healthcare and medications. The study took an interdisciplinary approach towards addressing a social problem and utilized existing scales (i.e., acculturation, gender-related attitudes, religiosity, spirituality, knowledge of HIV/AIDS, attitudes towards PLWHA, attitudes towards homosexuals) that were proven to have strong internal reliability. Professionals are encouraged to further explore the role social structures have in reinforcing ideology and implications for social disparities. An emphasis on the general population also allows for greater insight into how social

stratification is reinforced in society and unique circumstances historically oppressed and highly marginalized populations encounter from the power elite.

APPENDIX: A

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The Global HIV/AIDS Epidemic: A Timeline of Key Milestones

Introduction

On June 5, 1981, the United States Centers for Disease Control and Prevention issued its first warning about a relatively rare form of pneumonia among a small group of young gay men in Los Angeles, which was later determined to be AIDS-related. Since that time, millions more people have been infected with HIV worldwide, including 33 million estimated to be living with HIV/AIDS today. The Global HIV/AIDS Timeline is designed to serve as an ongoing reference tool for the many political, scientific, cultural, and community developments that have occurred over the history of the epidemic.

Pre-1981

While 1981 is generally referred to as the beginning of the HIV/AIDS epidemic, scientists believe that HIV was present years before the first case was brought to public attention.

1981

U.S. Centers for Disease Control and Prevention (CDC) reports first cases of rare pneumonia in young gay men in the June 5 MMWR, later determined to be AIDS. This marks the official beginning of the HIV/AIDS epidemic. CDC also issues report on highly unusual occurrence of rare skin cancer, Kaposi's Sarcoma, among young gay men in the July 4 MMWR.

First mainstream news coverage of the CDC's June 5 MMWR by the Associated Press and the LA Times on the same day it is issued. The San Francisco Chronicle reports on it the next day.

New York Times publishes its first news story on AIDS on July 3, 1981.

1982

U.S. CDC formally establishes the term Acquired Immune Deficiency Syndrome (AIDS); refers to four "identified risk factors" of male homosexuality, intravenous drug abuse, Haitian origin and hemophilia A.

ABC World News Tonight: October 18, 1982
Cause of AIDS epidemic still unknown, now present in many states.

First AIDS case reported in Africa.

First U.S. Congressional hearings held on HIV/AIDS.

"GRID" or "gay-related immune deficiency" increasingly used by the media and health care professionals, mistakenly suggesting inherent link between homosexuality and the syndrome.

Gay Men's Health Crisis, the first community-based AIDS service provider in the U.S., established in New York City.

City and County of San Francisco, working closely with San Francisco AIDS Foundation, Shanti Project and others, develops the "San Francisco Model of Care," which emphasizes home and community-based services.

1983

The U.S. Public Health Service issues recommendations for preventing transmission of HIV through sexual contact and blood transfusions.

Dr. Luc Montagnier in France isolates lymphadenopathy-associated virus (LAV), later to become known as human immunodeficiency virus or HIV.

U.S. CDC clarifies its use of term "high risk group" and urges that it not be used to justify discrimination or unwarranted fear of casual transmission.

U.S. CDC adds female sexual partners of men with AIDS as fifth risk group.

The Orphan Drug Act is signed into U.S. law, providing incentives to drug companies to develop therapies for rare diseases.

People living with AIDS (PWAs) take over plenary stage at U.S. conference and issue statement on the rights of PWAs referred to as The Denver Principles.

National Association of People with AIDS (NAPWA), National AIDS Network (NAN) and Federation of AIDS Related Organizations form.

AIDS Candlelight Memorial held for the first time.

1984

Dr. Robert Gallo of the United States, identifies HIV as the cause of AIDS.

ABC World News Tonight: November 23, 1984
San Francisco officials order bathhouses closed; major public controversy ensues and continues in Los Angeles, New York and other cities.

CDC states that abstention from intravenous drug use and reduction of needle-sharing "should also be effective in preventing transmission of the virus."

AIDS Action Council is formed by small group of AIDS service organizations from across the United States.

1985

First International AIDS Conference held in Atlanta. Hosted by U.S. Department of Health and Human Services (DHHS) and the World Health Organization (WHO).

At least one HIV/AIDS case has been reported from each region of the world.

First HIV case reported in China.

The U.S. Public Health Service issues first recommendations for preventing transmission of HIV from mother to child.

First HIV test licensed by the U.S. Food and Drug Administration (FDA), detects antibodies to HIV. Blood banks begin screening the U.S. blood supply.

Pentagon announces that it will begin testing all new recruits for HIV infection and will reject those who are positive.

ABC World News Tonight: October 2, 1985
Rock Hudson announces that he has AIDS and dies later this year.

Ryan White, an Indiana teenager with AIDS, is barred from school; goes on to speak out publicly against AIDS stigma and discrimination.

New York production of "The Normal Heart", by playwright Larry Kramer, opens; first major play about the early days of the AIDS epidemic.

American Foundation for AIDS Research (amfAR) is founded by Co-Chairs Mathilde Krim and Michael S. Gottlieb, and National Chair Elizabeth Taylor.

Project Inform founded to advocate for faster government approval of HIV drugs.

1986

President Reagan first mentions the word AIDS in public.

Informal distribution of clean syringes begins in Boston and New Haven

ABC World News Tonight: September 19, 1986
AZT, the first drug used to treat AIDS, begins clinical trials.

2nd International AIDS Conference, Paris, France.

U.S. Surgeon General Koop issues "Surgeon General's Report on AIDS", calling for education and condom use.

International Steering Committee for People with HIV/AIDS (ISC) created; becomes Global Network of People Living with HIV/AIDS (GNP+) in 1992.

First HIV cases reported in Russia and India.

National Academy of Science issues report critical of the U.S. response to "national health crisis;" calls for a $2

First panel of the AIDS Memorial Quilt created.

billion investment.

Ricky Ray, a nine-year-old hemophiliac with HIV, is barred from Florida school and his family's home is burned by arsonists in the following year.

Institute of Medicine report calls for a national education campaign and creation of National Commission on AIDS.

Robert Wood Johnson Foundation creates "AIDS Health Services Program", providing funding to hard hit U.S. cities; program is precursor to Ryan White CARE Act.

1987

First antiretroviral drug - Zidovudine or AZT (a nucleoside analog) - approved by U.S. FDA.

Global Programme on AIDS launched by the World Health Organization.

3rd International AIDS Conference, Washington, DC.

The AIDS Support Organisation (TASO) formed in Uganda.

ABC World News Tonight: April 1, 1987
President Reagan makes first public speech about AIDS; establishes Presidential Commission on HIV (Watkins Commission).

U.S. FDA sanctions first human testing of candidate vaccine against HIV.

U.S. FDA creates new class of experimental drugs, Treatment Investigational New Drugs (INDs), which accelerates drug approval by two to three years.

U.S. Congress approves $30 million in emergency funding to states for AZT.

U.S. adds HIV as a "dangerous contagious disease" to its immigration exclusion list; mandates testing of all applicants.

U.S. Congress adopts Helms Amendment banning use of federal funds for AIDS education materials that "promote or encourage, directly or indirectly, homosexual activities," often referred to as the "no promo homo" policy.

U.S. FDA adds HIV prevention as a new indication for male condoms.

U.S. CDC launches first AIDS-related public service announcements, "America Responds to AIDS".

U.S. CDC holds its first National Conference on HIV and communities of color.

"And the Band Played On: Politics, People and the AIDS Epidemic", a history of the early years of the epidemic by Randy Shilts, is published.

Entertainer Liberace dies of AIDS.

AIDS Memorial Quilt displayed on National Mall in Washington, DC for first time.

The National Black Leadership Commission on AIDS, the National Minority AIDS Council, and the National Task Force on AIDS Prevention form in the U.S.

AIDS Coalition to Unleash Power (ACT UP) established in New York in response to proposed cost of AZT; the price of AZT is subsequently lowered.

First issue of "AIDS Treatment News" published to provide HIV treatment information to community members.

1988

World AIDS Day first declared by World Health Organization (WHO) on December 1.

UNAIDS reports that the number of women living with HIV/AIDS in sub-Saharan Africa exceeds that of men.

4th International AIDS Conference, Stockholm, Sweden.

International AIDS Society Forms.

U.S. Surgeon General and CDC mail brochure, "Understanding AIDS" to all

U.S. households; first and only national mailing of its kind.

The U.S. Health Omnibus Programs Extension (HOPE) Act of 1988 authorizes the use of federal funds for AIDS prevention, education, and testing.

U.S. National Institutes of Health (NIH) establishes Office of AIDS Research (OAR) and AIDS Clinical Trials Group (ACTG).

U.S. FDA allows the importation of unapproved drugs for persons with life-threatening illnesses, including HIV/AIDS.

ACT UP demonstrates at FDA headquarters in protest of slow pace of drug approval process.

First comprehensive needle exchange program (NEP) established in North America in Tacoma, WA. New York City creates first government-funded NEP and San Francisco establishes what becomes largest NEP in the nation.

ABC World News Tonight: January 8, 1988
WHO reports AIDS cases has jumped 56% worldwide.

ABC World News Tonight: June 17, 1988
A scientist injects himself with an experimental vaccine to help find a cure.

ABC World News Tonight: June 24, 1988
A special commission on AIDS presents a tough report to President Reagan.

ABC World News Tonight: August 29, 1988
A young girl with AIDS can only attend school if she is in a glass enclosure.

ABC World News Tonight: October 6, 1988
A reversal in Department of Justice policy: AIDS/HIV patients can no longer be discriminated against.

ABC World News Tonight: October 17, 1988
A TV commercial campaign about AIDS awareness is aimed at minorities.

1989

First guidelines for the prevention of Pneumocystis carinii pneumonia (PCP), an AIDS-related opportunistic infection and major cause of morbidity and mortality for people with HIV, are issued by U.S. CDC.

ABC World News Tonight: April 6, 1989
A foreigner with AIDS is not allowed into the U.S. because he has the virus.

5th International AIDS Conference ("The Scientific and Social Challenge of AIDS"), Montreal, Canada.

U.S. Congress creates the National Commission on AIDS.

Head of NIH's National Institute of Allergy and Infectious Diseases (NIAID), Dr. Anthony Fauci, endorses parallel track policy, giving those that do not qualify for clinical trials access to experimental treatments.

AIDS activists stage several major protests about AIDS drugs during the year, including at the Golden Gate Bridge, the New York Stock Exchange, and U.S. headquarters of Burroughs Wellcome.

ABC World News Tonight: December 1, 1989
First "Day Without Art" organized by Visual AIDS to acknowledge the impact of AIDS on the arts.

Dancer and choreographer Alvin Ailey dies of AIDS.

Photographer Robert Mapplethorpe dies of AIDS.

1990

6th International AIDS Conference ("AIDS in the Nineties: From Science to Policy"), San Francisco, CA. To protest U.S. immigration policy, domestic and international non-governmental groups boycott the conference. (The 1992 conference, scheduled to take place in Boston, is moved to Amsterdam.)

ABC World News Tonight: April 8, 1990

ABC World News Tonight: April 9, 1990

Ryan White dies at the age of 18.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 is enacted by the U.S. Congress, providing federal funds for community-based care and treatment services. In first year, it is funded at $220.5 million.

U.S. FDA approves use of AZT for pediatric AIDS.

Americans with Disabilities Act of 1990 enacted by the U.S. Congress, prohibiting discrimination against individuals with disabilities, including people living with HIV/AIDS.

First National Conference on Women and AIDS held in Boston.

"Women, AIDS and Activism," developed by ACT UP's Women's Caucus, is published, becoming the first book of its kind.

Pop artist Keith Haring dies of AIDS.

Kimberly Bergalis, of Florida, is believed to have been infected with HIV by her dentist, causing major public debate.

1991

NBA legend Earvin "Magic" Johnson announces that he is HIV-positive and retires from basketball.

7th International AIDS Conference ("Science Challenging AIDS"), Florence, Italy.

Housing Opportunities for People with AIDS (HOPWA) Act of 1991 enacted by the U.S. Congress, to provide housing assistance to people living with AIDS through grants to U.S. states and local communities.

U.S. CDC recommends restrictions on the practice of HIV-positive health care workers and Congress enacts law requiring states to take similar action.

ICASO (International Council of AIDS Service Organizations) forms as global network of non-governmental and community-based organizations.

Red ribbon introduced as the international symbol of AIDS awareness at the Tony Awards by Broadway Cares/Equity Fights AIDS and Visual AIDS.

Freddie Mercury, lead singer of the rock band Queen, dies of AIDS.

1992

8th International AIDS Conference ("A World United Against AIDS"), Amsterdam; would have taken place in Boston, but was moved due to U.S. immigration ban.

ABC World News Tonight: December 18, 1992
Teenager Ricky Ray, whose home was torched because he and his siblings were HIV-positive, dies of AIDS.

International Community of Women Living with HIV/AIDS (ICW) is founded.

FDA licenses first rapid HIV test, which provides results in as little as ten minutes.

AIDS becomes number one cause of death for U.S. men ages 25 to 44.

Mary Fisher and Bob Hattoy, each HIV-positive, address the Republican and Democratic National Conventions, respectively.

Tennis star Arthur Ashe announces he has AIDS.

1993

President Clinton establishes White House Office of National AIDS Policy (ONAP).

9th International AIDS Conference, Berlin, Germany.

U.S. FDA approves female condom for sale in U.S.

Women's Interagency HIV Study (WIHS) and HIV Epidemiology Study (HERS) begin; both major U.S.

President Clinton signs HIV immigration exclusion policy into law.

federally-funded research studies on women and HIV/AIDS.

U.S. Congress enacts the NIH Revitalization Act, giving the OAR primary oversight of all NIH AIDS research; requires NIH and other research agencies to expand involvement of women and minorities in all research.

U.S. CDC expands case definition of AIDS to reflect fuller spectrum of the disease, including adding a condition specific to women and those more prevalent among injection drug users.

U.S. CDC initiates HIV prevention community planning process for local distribution of federal prevention funding.

"Angels in America", Tony Kushner's play about AIDS, wins the Tony Award and Pulitzer Prize.

First annual "AIDSWatch" - hundreds of community members from across the U.S. converge in Washington, DC to lobby Congress for increased AIDS funding.

World class ballet dancer Rudolf Nureyev dies of AIDS.

Katrina Haslip, leading advocate for women with AIDS in prison, dies of AIDS.

1994

U.S. Public Health Service recommends use of AZT by pregnant women to reduce perinatal transmission of HIV, based on “076” study showing up to 70% reduction in transmission.

10th International AIDS Conference ("The Global Challenge of AIDS: Together for the Future"), Yokohama, Japan.

AIDS becomes leading cause of death for all Americans ages 25 to 44; remains so through 1995.

U.S. FDA approves an oral HIV test, the first non-blood based antibody test

NIH issues guidelines requiring applicants for NIH grants to address

for HIV.

"the appropriate inclusion of women and minorities in clinical research."

Elizabeth Glaser, co-founder of the Pediatric AIDS Foundation, dies of AIDS.

Pedro Zamora, a young gay man living with HIV, appears on the cast of MTV's popular show, The Real World; dies later this year at age 22.

ABC World News Tonight: February 22, 1994

Randy Shilts, author of "And the Band Played On" dies of AIDS at age 42.

1995

First protease inhibitor, saquinavir, approved in record time by the U.S. FDA, ushering in new era of highly active antiretroviral therapy (HAART).

President Clinton establishes Presidential Advisory Council on HIV/AIDS.

First guidelines for the prevention of opportunistic infections in persons infected with HIV issued by U.S. CDC.

First White House Conference on HIV/AIDS.

First National HIV Testing Day created by the National Association of People with AIDS.

ABC World News Tonight: February 23, 1995

Olympic Gold Medal diver Greg Louganis discloses that he is living with HIV, leading to public debate regarding disclosure of HIV status.

Rap artist Eric Wright (Eazy-E of NWA) dies of AIDS.

1996

11th International AIDS Conference ("One World, One Hope"), Vancouver, Canada; highlights effectiveness of HAART, creating period of optimism.

Joint United Nations Programme on HIV/AIDS (UNAIDS) begins operations; established to advocate for global action on the epidemic, and to coordinate HIV/AIDS efforts across the UN system.	Brazil begins national ARV distribution, first developing country to do so.
U.S. FDA approves first non-nucleoside reverse transcriptase inhibitor (NNRTI), nevirapine.	U.S. FDA approves HIV urine test and first HIV home testing and collection kit.
U.S. FDA approves viral load test, a new test that measures the level of HIV in the body.	The number of new AIDS cases diagnosed in the U.S. declines for first time in history of epidemic, though experience varies by sex, race and ethnicity.
HIV no longer leading cause of death for all Americans ages 25-44; remains leading cause of death for African Americans in this age group.	U.S. Congress reauthorizes the Ryan White CARE Act.
The Levine Committee, a blue ribbon advisory panel, calls for overhaul of NIH AIDS research, including stronger role for OAR and increased support for vaccine-related and investigator-initiated research.	International AIDS Vaccine Initiative (IAVI), an NGO, forms to speed the search for an effective HIV vaccine.
Time Magazine names AIDS researcher Dr. David Ho as its "Man of the Year."	Former heavyweight boxing champion Tommy Morrison announces he is HIV-positive.
ABC World News Tonight: February 1, 1996 Interview with AIDS researcher Dr. David Ho on a new AIDS drug.	*ABC World News Tonight*: February 1, 1996 ABC News poll on public attitudes towards AIDS
ABC World News Tonight: July 8, 1996	*ABC World News Tonight*: July 8, 1996

A period of optimism begins- being HIV-positive is no longer a death sentence.

AIDS awareness ad campaigns target everyone, not only high-risk groups.

ABC World News Tonight: July 8, 1996
Images of what the AIDS virus looks like in the body.

1997

AIDS-related deaths in the U.S. decline by more than 40 percent compared to the prior year, largely due to HAART.

President Clinton announces goal of finding an effective vaccine in 10 years and the creation of Dale and Betty Bumpers Vaccine Research Center.

U.S. Congress enacts FDA Modernization Act of 1997, codifying accelerated approval process, and allowing dissemination of information about off-label uses of drugs.

1998

Minority AIDS Initiative created in U.S., after African American leaders declare a "state of emergency" and Congressional Black Caucus (CBC) calls on the Department of Health and Human Services to do the same.

12th International AIDS Conference ("Bridging the Gap"), Geneva, Switzerland.

U.S Department of Health and Human Services issues first national guidelines for the use of antiretroviral therapy in adults.

First large scale human trials (Phase III) for an HIV vaccine begin.

Despite earlier optimism, several reports indicate growing signs of treatment failure and side effects from HAART.

Ricky Ray Hemophilia Relief Fund Act of 1998 enacted by U.S. Congress, authorizing payments to hemophiliacs infected through unscreened blood-clotting agents between 1982 and 1987.

U.S. Department of Health and Human Services Secretary Shalala determines that needle exchange programs are effective and do not encourage the use of illegal drugs, but Clinton Administration does not lift the ban on

use of federal funds for such purposes.

The U.S. Supreme Court in Bragdon v. Abbot rules that the Americans with Disabilities Act covers those in earlier stages of HIV disease, not just AIDS.

Treatment Action Campaign (TAC) forms in South Africa; grassroots movement pushes for access to treatment.

Global AIDS and human rights activists Jonathan Mann and Mary Lou Clements-Mann are killed in a plane crash en route to World Health Organization in Geneva.

1999

President Clinton announces "Leadership and Investment in Fighting an Epidemic" (LIFE) Initiative to address the global epidemic; leads to increased funding.

First human vaccine trial in a developing country begins in Thailand.

Congressional Hispanic Caucus, with the Congressional Hispanic Caucus Institute, convenes Congressional hearing on impact of HIV/AIDS on Latino community.

Reggie Williams, founder of the National Task Force on AIDS Prevention, dies of AIDS.

2000

13th International AIDS Conference ("Breaking the Silence"), Durban, South Africa; first to be held in a developing nation, heightens awareness of the global pandemic.

U.S. and UN Security Councils each declare HIV/AIDS a security threat.

G8 Leaders acknowledge need for additional HIV/AIDS resources during Okinawa Meeting.

President Clinton issues Executive Order to assist developing countries in importing and producing generic forms of HIV treatments.

UNAIDS, WHO and other global health groups announce joint initiative with five major pharmaceutical manufacturers to negotiate reduced prices for AIDS drugs in developing countries.

Global AIDS and Tuberculosis Relief Act of 2000 enacted by U.S. Congress, authorizing up to $600 million for U.S. global efforts.

Millennium Development Goals, announced as part of Millennium Declaration, include reversing the spread of HIV/AIDS, malaria and TB as one of 8 key goals.

U.S. Congress reauthorizes the Ryan White CARE Act for the second time.

President Clinton announces Millennium Vaccine Initiative, creating incentives for development and distribution of vaccines against HIV, TB and malaria.

U.S. CDC reports that, among men who have sex with men in the U.S., African American and Latino cases exceed those among whites.

President Clinton creates first ever Presidential Envoy for AIDS Cooperation.

U.S. CDC forms Global AIDS Program (GAP).

U.S. Department of Health and Human Services approves first state 1115 Medicaid expansion waivers for low-income people with HIV in Maine, Massachusetts and District of Columbia; in 2001, Massachusetts becomes first state to enroll new clients.

2001

United Nations General Assembly convenes first ever special session on AIDS, "UNGASS"

ABC World News Tonight: June 25, 2001

June 5 marks 20 years since first AIDS case reported.

The state of treatment for AIDS patients.

First Annual National Black HIV/AIDS Awareness Day in the United States.

UN Secretary-General Kofi Annan calls for a global fund, a "war chest", to fight AIDS, during African Summit on HIV/AIDS in Abuja, Nigeria.

The World Trade Organization, meeting in Doha, Qatar, announces "DOHA Agreement", to allow developing countries to buy or manufacture generic medications to meet public health crises, such as HIV/AIDS.

Newly appointed U.S. Secretary of State, Colin Powell, reaffirms U.S. statement that HIV/AIDS is a national security threat.

Generic drug manufacturers offer to produce discounted, generic forms of HIV/AIDS drugs; several major pharmaceutical manufacturers agree to offer further reduced drugs prices in developing countries.

2002

The Global Fund to Fight AIDS, Tuberculosis, and Malaria begins operations; approves first round of grants later this year.

ABC World News Tonight: July 7, 2002
AIDS & African Americans

HIV is leading cause of death worldwide, among those aged 15-59.

UNAIDS reports that women comprise about half of all adults living with HIV/AIDS worldwide.

14th International AIDS Conference ("Knowledge and Commitment"), Barcelona, Spain.

U.S. National Intelligence Council releases report on "Next Wave" of the Epidemic, focused on India, China, Russia, Nigeria, and Ethiopia.

Approval of OraQuick Rapid HIV-1 Antibody Test, by U.S. FDA; first rapid test to use finger prick. OraQuick granted a Clinical Laboratory

Improvement Amendments (CLIA) waiver in 2003, enabling the test to be performed outside of the laboratory, allowing more widespread use.

2003

President Bush announces PEPFAR, the President's Emergency Plan for AIDS Relief, during the State of the Union Address; PEPFAR is a five-year, $15 billion initiative to address HIV/AIDS, tuberculosis, and malaria primarily in hard hit countries.

"3 by 5" Initiative announced by World Health Organization, to bring treatment to 3 million people by 2005.

The William J. Clinton Presidential Foundation secures price reductions for HIV/AIDS drugs from generic manufacturers, to benefit developing nations.

First Annual National Latino AIDS Awareness Day in the United States.

The South African Government announces new antiretroviral treatment program.

G8 Evian Summit includes special focus on HIV/AIDS, new commitments to the Global Fund announced.

2004

15th International AIDS Conference ("Access for All"), Bangkok, Thailand; first to be held in Southeast Asia.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria holds first ever "Partnership Forum," in Bangkok, Thailand; 400 delegates participate.

Leaders of the Group of Eight (G8) nations call for creation of "Global HIV Vaccine Enterprise," a consortium of government and private sector groups designed to coordinate and accelerate research efforts to find an effective HIV vaccine.

U.S. Department of Health and Human Services announces expedited review process by FDA for fixed dose combination and co-packaged products - to be used by U.S. in purchasing medications under PEPFAR.

PEPFAR, President Bush's Emergency Plan for AIDS Relief, begins first round of funding.

UNAIDS launches The Global Coalition on Women and AIDS to raise the visibility of the epidemic's impact on women and girls around the world.

OraQuick Rapid HIV-1 Antibody Test approved for use with oral fluid by U.S. FDA. Oral fluid rapid test is granted a CLIA waiver.

Keith Cylar, long time AIDS activist and founder and co-president of Housing Works, Inc. in the United States, dies at age 45.

ABC World News Tonight: July 12, 2004
AIDS in China

ABC World News Tonight: July 13, 2004
Kofi Annan compares the war on terror to the war on AIDS.

2005

U.N. General Assembly High-Level Meeting on HIV/AIDS to review progress on targets set at 2001 U.N. General Assembly Special Session on HIV/AIDS (UNGASS).

United Kingdom hosts G8 Summit at Gleneagles; focus on development in Africa, including HIV/AIDS.

At historic and unprecedented joint press conference, the World Health Organization, UNAIDS, the United States Government, and the Global Fund to Fight AIDS, Tuberculosis and Malaria announce results of joint efforts to increase the availability of antiretroviral drugs in developing countries. An estimated 700,000 people had been reached by the end of 2004.

At World Economic Forum's Annual

First Annual National Asian and Pacific

Meeting in Davos, Switzerland, priorities include a focus on addressing HIV/AIDS in Africa and other hard hit regions of the world.

Islander HIV/AIDS Awareness Day in the United States.

The U.S. Food and Drug Administration grants "Tentative Approval to Generic AIDS Drug Regimen for Potential Purchase Under the President's Emergency Plan for AIDS Relief", marking first ever approval of an HIV drug regimen manufactured by a non-U.S.-based generic pharmaceutical company, under FDA's new expedited review process.

Ranbaxy becomes first Indian drug manufacturer to gain U.S. Food and Drug Administration approval to produce generic antiretroviral for PEPFAR.

2006

June 5 marks a quarter century since first AIDS case reported.

United Nations convenes follow-up meeting and issues progress report on the implementation of the Declaration of Commitment on HIV/AIDS.

16th International AIDS Conference ("Time to Deliver"), Toronto, Canada.  View kaisernetwork.org's online coverage of the conference.

U.S. Centers for Disease Control and Prevention releases revised HIV testing recommendations for health-care settings, recommending routine HIV screening for all adults, aged 13-64, and yearly screening for those at high risk.

First Eastern European and Central Asian AIDS conference (EECAAC) held (Moscow).

Russia hosts G8 Summit for first time (St. Petersburg); HIV/AIDS is addressed.

U.S. Congress reauthorizes the Ryan White CARE Act for the third time.

First Annual National Women and Girls HIV/AIDS Awareness Day in the United States.

2007

President Bush calls on Congress to reauthorize PEPFAR at $30 billion over 5 years (White House Press Release)

International HIV/AIDS Implementers Meeting held in Kigali, Rwanda and hosted by the Rwandan Government. It draws over 1,500 delegates from around the world to share lessons on HIV prevention, treatment, and care from the field. Co-sponsors include PEPFAR, The Global Fund, UNAIDS, WHO, UNICEF, The World Bank, and GNP+. View kaisernetwork.org's online coverage of the conference.

The World Health Organization and UNAIDS issue new guidance recommending "provider-initiated" HIV testing in health-care settings.

The World Health Organization and UNAIDS recommend that "male circumcision should always be considered as part of a comprehensive HIV prevention package."

2008

U.S. Congress reauthorizes PEPFAR for an additional 5 years at up to $48 billion; the legislation ends the statutory HIV travel and immigration ban.

17th International AIDS Conference ("Universal Action Now"), Mexico City; first to be held in Latin America.

View kaisernetwork.org's online coverage of the conference

International 2008 HIV/AIDS Implementers Meeting held in Kampala, Uganda and hosted by the Ugandan Government. Co-sponsors include PEPFAR, The Global Fund, UNAIDS, WHO, UNICEF, The World Bank, and GNP+.

View kaisernetwork.org's online coverage of the conference

United Nations convenes UNGASS follow-up meeting and issues progress

U.S. CDC releases new HIV incidence estimates for the United States, showing

report on the implementation of the Declaration of Commitment on HIV/AIDS.

that the U.S. epidemic is worse than previously thought.

2009

President Obama launches the Global Health Initiative (GHI), a six-year, $63 billion effort to develop a comprehensive approach to addressing global health in low and middle income countries, with PEPFAR as a core component.

Newly elected President Obama calls for the first ever National HIV/AIDS Strategy for the United States.

The Obama Administration officially lifts HIV travel and immigration ban by removing the final regulatory barriers to entry, to take effect in January 2010. Leads to announcement that the International AIDS Conference will return to the United States for the first time in more than 20 years, and be held in be held in Washington, DC in 2012.

U.S. Congress eliminates long-standing statutory ban on the use of federal funding for needle exchange in the United States.

2010

Removal of U.S. HIV travel and immigration ban officially begins.

The XVIII International AIDS Conference held in Vienna, Austria. The theme is "Rights Here, Right Now," with an emphasis on human rights as a central part of the HIV response."

United Nations to convene summit to accelerate progress toward the 2015 UN Millennium Development Goals.

Obama Administration releases first comprehensive National HIV/AIDS Strategy for the United States in July.

2011

June 5 marks 30 years since first AIDS case reported.

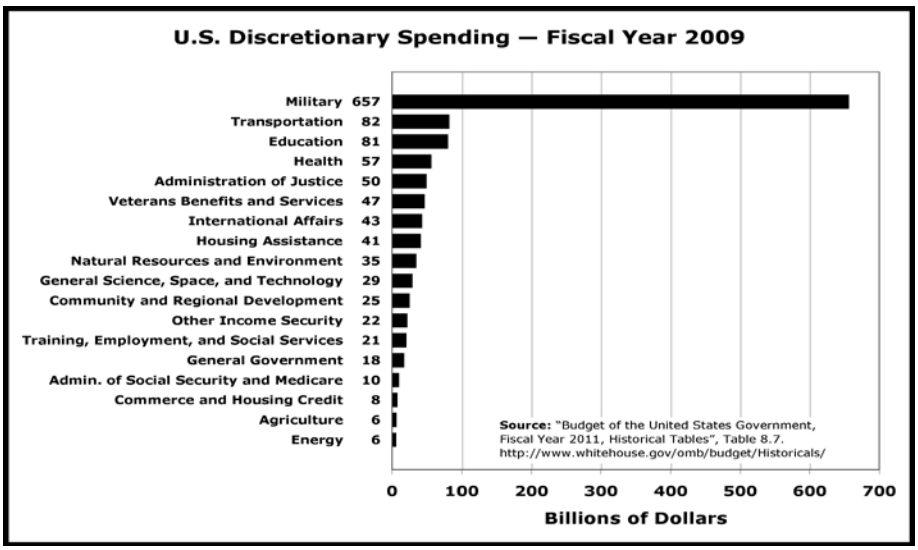
2012

The XIX International AIDS Conference to be held in Washington, DC, marking the first time the conference has been held in the United States since 1990.

(as cited in Kaiser Foundation, 2011)

Appendix B

Table 1



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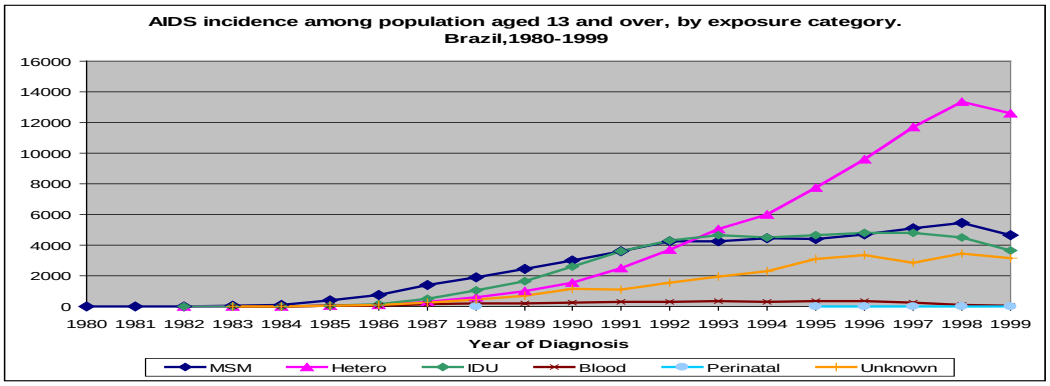
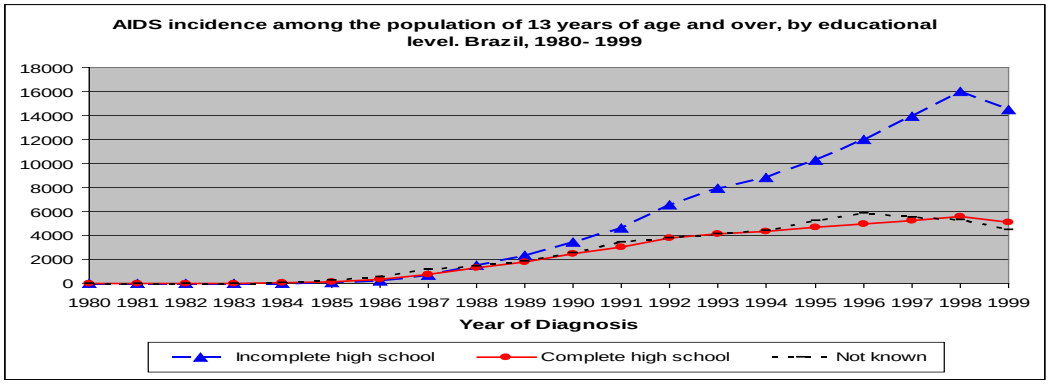


Source: SINAN, cases notified up to December 2003. (Graphs were adapted from Monitor AIDS, 2005)

Table 3



Source: SINAN, cases notified up to December 2003. (Graphs were adapted from Monitor AIDS, 2005)

APPENDIX C: UNAIDS Proposal for Faith-based Initiatives

2. Goal, objectives and guiding principles

2.1. Goal

The goal of the UNAIDS–FBO strategic framework is to encourage stronger partnerships between UNAIDS and FBOs in order to achieve universal access to HIV prevention, treatment, care and support, which includes the integration of FBOs in comprehensive national AIDS responses.

2.2. Objectives

The objectives of the UNAIDS–FBO strategic framework are to:

- Encourage global and national religious leaders to take supportive public action in the AIDS response.
- Create strong partnerships between UNAIDS and established FBOs working on HIV.
- Promote strengthened links, including coordination and oversight, with FBOs at the country level to ensure that there is an appropriate interface as part of a comprehensive national AIDS response.
- Strengthen the capacity of FBOs to work on HIV issues and the capacity of UNAIDS staff to work with FBOs.
- Target FBOs not yet working on HIV to include HIV-related activities in their work.
- Mobilize local faith communities to become involved in the local AIDS response.
- Identify and document examples of FBO good practice.

2.3. Guiding principles

Guiding principles for the Global response to AIDS are found in the Resolution adopted by the General Assembly 60/262, the Political Declaration on HIV/AIDS.

In addition UNAIDS partnerships are based upon the following guiding principles:

- People living with HIV must be leaders in the design, programming, implementation, research, monitoring and evaluation of all programmes and policies affecting their lives.
- Human-rights-based approaches, gender equality and the greater involvement of people living with HIV principle are the foundation of UNAIDS' partnership work.
- The value of partnerships must be measured by the extent to which they contribute to reducing the number of people becoming infected with HIV and to reducing the impact on those people living with or affected by HIV.
- The focus of partnerships must be on supporting national ownership, country-led approaches and accountability.
- Resources invested are aligned with and used to support national priorities and to benefit people living with or affected by HIV in the areas of prevention, care and support, treatment and impact mitigation.

- Partnerships must result in institutional and systems strengthening11 (i.e. there must be commitment to strengthen the capacities of national institutions to provide leadership and coordination in order to achieve universal access targets).
- The best available scientific evidence and technical knowledge should inform the work of partnerships.

(UNAIDS, 2009, p.11-12)

APPENDIX D: EMAIL

Greetings,

I am currently a Doctoral Student in Social Welfare at the City University of New York.
I would greatly appreciate if you can forward the following email to your network and help me recruit Latinos (18yo and older) to complete an online survey.

Thank you for your support in promoting the research study. Also, feel free to contact me if you have further questions.

Moctezuma Garcia
Principal Investigator
Dímelo Research Study
English survey: https://survey.gc.cuny.edu/s?s=926
Español: https://survey.gc.cuny.edu/s?s=926&lang=es_US
Research Website: http://www.facebook.com/dimelo.garcia

To Whom It May Concern:

You are invited to participate in an online survey that should take approximately 30 minutes to complete. The research study is exploring how religion and culture influences your thoughts related to the HIV/AIDS epidemic.

You must meet the following characteristics to be eligible for the study:

- 18 years of age or older
- Identify as Hispanic, Latino, or from a Latin American country

The online survey is anonymous and no identifying information will be linked to the completed survey. A lottery will also be administered to randomly select 24 winners for the following prizes totaling $1,100 in gift cards:

4 winners will receive a $100.00 Visa gift card
8 winners will receive a $50.00 Visa gift card
12 winners will receive a $25.00 Visa gift card

Upon completion of the survey you will have an opportunity to send an email to enter the lottery drawing. To ensure confidentiality, your email or name and address will be kept separate from the data. Participants that have been randomly selected for the lottery drawing will be notified that they won a prize and all other emails will be destroyed. Participants registered for the lottery will receive confirmation with a unique lottery number and the lottery number of winners will be posted on the internet website. Your participation is voluntary and you may withdraw from this study at any time.

Click on the following link to start the survey:
https://survey.gc.cuny.edu/s?s=926

The survey also allows you to save your answers and return to complete the survey if necessary.

Feel free to forward any questions or concerns related to the study to Moctezuma Garcia the Principal Investigator of the study at (773) 388-8883 and email at mgarcia@gc.cuny.edu or Bernadette Hadden the Ph.D. Advisor at (212) 452-7027 and email at bhadden@hunter.cuny.edu Mr. Garcia is a Doctoral Candidate in Social Welfare at The Graduate Center of the City University of New York (CUNY).

City University of New York IRB Protocol # 10-07-191-0135

APPENDIX E: DIMELO CONSENT FORM

My name is Moctezuma Garcia and I am a doctoral student in the Social Welfare Ph.D. Program at The Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project, entitled "Dimelo (tell me about it): What influence does religion and culture have on HIV/AIDS among Latinos?" The study is expected to gain a greater understanding on how religion and culture influences issues related to HIV/AIDS among Latinos. The following information will provide you with an overview of the study to help you reach a decision to participate in the study.

The survey should take approximately 30 minutes to complete and the questions will ask you about your thoughts on: culture, gender attitudes, religion, spirituality, HIV/AIDS, sexuality, and sexual behaviors. The survey is anonymous and any information gathered will be kept strictly confidential. No identifiable information such as your name, address, or phone number will be on the survey.

You will not be compensated for participating in the study. However, you will be eligible to enter a lottery at the end of the survey. Any information emailed to Mr. Garcia for the lottery drawing will not be sent through a secure server like those used for credit card transactions so there is a slight chance that emails could be viewed by unauthorized third parties, such as computer hackers. You can also complete a contact form and mail it to Mr. Garcia to prevent unauthorized third parties from accessing the email account.

Lottery winners will be randomly selected and there will be a total of $1,100 in gift cards for 24 winners (4:$100.00, 8:$50.00, & 12:$25.00). Participants registered for the lottery will receive confirmation with a unique lottery number and the lottery number of winners will be posted on the internet website. Your contact information will be kept strictly confidential and will not be linked to your completed survey. All responses collected from the survey will be kept in a secure server separate from the lottery entries. Lottery entries will be kept in a separate database from the questionnaires and will be destroyed as soon as prizes have been distributed. Lottery entries received through the mail will be kept in a secure locked file.

The risks from participating in this study are no more than encountered in everyday life. Some questions may cause you to feel some minor discomfort or embarrassment, but it is not greater than what you may experience in your daily life. You may also refuse to answer any questions and stop participating in the study at any time.

There are no direct benefits. However, your participation in the study has the potential of assisting professionals in enhancing healthcare services for Latinos and combating the spread of HIV infections among Latinos.

I may publish results of the study, but names of people, or any identifying characteristics, will not be used in any of the publications. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

If you have any questions about this research, you can contact me at (773) 388-8883 or mgarcia@gc.cuny.edu, or my advisor Dr. Bernadette Hadden at (212) 452-7027 and email at bhadden@hunter.cuny.edu. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

Thank you for your participation in the study. You can print this consent form or email me a request for the consent form and I will send you an electronic copy of this form.

Agreement to Continue
The following option indicates that you have read the information provided above and your decision to join the study:

- Yes – I agree to participate in the study.
- No – I refuse to participate in the study.

Appendix F: Zero-Order Correlations for predictors of HIV Knowledge

		1	2	3	4	5	6	7	8
1.Acculturation	Pearson Correlation	1							
	Sig. (2-tailed)								
	N	291							
2.Religiosity	Pearson Correlation	-.125*	1						
	Sig. (2-tailed)	0.047							
	N	254	271						
3.SWB	Pearson Correlation	0.036	.449**	1					
	Sig. (2-tailed)	0.551	0.000						
	N	270	248	284					
4.Education	Pearson Correlation	.277**	-.141*	0.066	1				
	Sig. (2-tailed)	0.000	0.021	0.271					
	N	285	265	278	304				
5.Household income	Pearson Correlation	.258**	-0.049	.181**	.335**	1			
	Sig. (2-tailed)	0.000	0.431	0.002	0.000				
	N	286	265	279	304	305			
6.Age	Pearson Correlation	-0.023	0.090	-0.008	0.056	.281**	1		
	Sig. (2-tailed)	0.703	0.149	0.896	0.338	0.000			
	N	279	259	272	296	297	297		
7.Gender_attitude	Pearson Correlation	-0.049	.294**	0.114	-.143*	-0.097	-0.034	1	
	Sig. (2-tailed)	0.411	0.000	0.056	0.013	0.093	0.558		
	N	286	268	279	299	300	292	306	
8.HIV_Know	Pearson Correlation	.225**	-0.088	-0.076	.275**	0.176	-0.059	-0.076	1
	Sig. (2-tailed)	0.000	0.163	0.215	0.000	0.003	0.333	0.202	
	N	273	253	267	281	282	274	283	288

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Appendix G: Zero-Order Correlations for predictors of attitudes towards PLWHA

		1	2	3	4	5	6	7	8
1.Acculturation	Pearson Correlation	1							
	Sig. (2-tailed)								
	N	291							
2.Religiosity	Pearson Correlation	-.125*	1						
	Sig. (2-tailed)	0.047							
	N	254	271						
3.SWB	Pearson Correlation	0.036	.449**	1					
	Sig. (2-tailed)	0.551	0.000						
	N	270	248	284					
4.Education	Pearson Correlation	.277**	-.141*	0.066	1				
	Sig. (2-tailed)	0.000	0.021	0.271					
	N	285	265	278	304				
5.Household income	Pearson Correlation	.258**	0.049	0.181	0.335	1			
	Sig. (2-tailed)	0.000	0.431	0.002	0.000				
	N	286	265	279	304	305			
6.Age	Pearson Correlation	-0.023	0.090	-0.008	0.056	.281**	1		
	Sig. (2-tailed)	0.703	0.149	0.896	0.338	0.000			
	N	279	259	272	296	297	297		
7.Gender_attitude	Pearson Correlation	-0.049	.294**	0.114	-.143*	-0.097	-0.034	1	
	Sig. (2-tailed)	0.411	0.000	0.056	0.013	0.093	0.558		
	N	286	268	279	299	300	292	306	
8.HIV_Attitude	Pearson Correlation	0.006	.168**	0.029	-0.115	-0.051	-0.027	.290**	1
	Sig. (2-tailed)	0.922	0.008	0.635	0.056	0.392	0.660	0.000	
	N	269	251	266	278	279	271	282	286

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Appendix H: Zero-Order Correlations for predictors of attitudes towards homosexuals

		1	2	3	4	5	6	7	8
1.Acculturation	Pearson Correlation	1							
	Sig. (2-tailed)								
	N	291							
2.Religiosity	Pearson Correlation	-.125*	1						
	Sig. (2-tailed)	0.047							
	N	254	271						
3.SWB	Pearson Correlation	0.036	.449**	1					
	Sig. (2-tailed)	0.551	0.000						
	N	270	248	284					
4.Education	Pearson Correlation	.277**	-.141*	0.066	1				
	Sig. (2-tailed)	0.000	0.021	0.271					
	N	285	265	278	304				
5.Household income	Pearson Correlation	.258**	-0.049	.181**	.335**	1			
	Sig. (2-tailed)	0.000	0.431	0.002	0.000				
	N	286	265	279	304	305			
6.Age	Pearson Correlation	-0.023	0.090	-0.008	0.056	.281**	1		
	Sig. (2-tailed)	0.703	0.149	0.896	0.338	0.000			
	N	279	259	272	296	297	297		
7.Gender_attitude	Pearson Correlation	-0.049	.294**	0.114	-.143*	-0.097	-0.034	1	
	Sig. (2-tailed)	0.411	0.000	0.056	0.013	0.093	0.558		
	N	286	268	279	299	300	292	306	
8.HOMO_Attitude	Pearson Correlation	-.169**	.249**	-0.075	-.249**	-0.11	.222**	.352**	1
	Sig. (2-tailed)	0.005	0.000	0.218	0.000	0.061	0.000	0.000	
	N	279	263	272	291	292	285	294	298

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

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