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Preventing HIV among Latino and African American Gay and Bisexual Men in a Context of HIV-Related Stigma, Discrimination, and Homophobia: Perspectives of Providers

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Abstract

HIV-related stigma, discrimination, and homophobia impede community based efforts to combat HIV disease among Latino and African American gay and bisexual men. This commentary highlights ways to address these social biases in communities of color in Los Angeles from the perspectives of staff from HIV prevention programs. Information was collected from HIV prevention program staff participating in a two-day symposium. The outcomes from the symposium offer strategies for developing and implementing HIV prevention services for Latino and African American gay and bisexual men, which include: 1) addressing social biases present in a community that can hinder, and even prohibit, utilization of effective HIV prevention programs; 2) recasting HIV prevention messages in a broader social or health context; 3) developing culturally appropriate HIV prevention messages; 4) exploring new modalities and venues for delivering HIV prevention messages that are appropriate for gay and bisexual men of color and the communities in which they live; and 5) broadening the target of HIV prevention services to include service providers, local institutions and agencies, and the community at-large. These strategies underscore the need to consider the social and contextual factors of a community when designing and implementing HIV prevention programs.

INTRODUCTION

HIV-related stigma and discrimination remain among the greatest impediments to local efforts to combat HIV disease.^{1–9} In 2000, Peter Piot, executive director of UNAIDS, identified stigma as a “continuing challenge” that prevents concerted action at community, national and global levels to address this epidemic.¹⁰ UNAIDS defined HIV stigmatization as a “social process of devaluation that reinforces negative thoughts about persons living with HIV and AIDS.”⁸ As a social process, HIV-related stigma often results in acts of prejudice and discrimination towards individuals or groups living with the disease.

A consequence of HIV-related stigma and discrimination is a negative effect on both HIV prevention efforts as well as care for individuals living with HIV. The social forces of stigma and discrimination can create significant barriers to HIV testing, restrict utilization of prevention programs, and hinder the adoption of preventive behaviors such as condom use and disclosure of HIV status to sex partners.^{1,2,5–7,11} In one U.S. study, for example, 59% of

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men who had never been tested for HIV cited fear of negative social consequences as an important reason for not seeking testing.³ These social biases can also hinder utilization of health care by HIV-positive individuals and can negatively affect the quality of care provided to HIV-positive individuals.^{1,4,6,11–13} In a recent survey, the American Civil Liberties Union found that people with HIV/AIDS in the U.S. were denied medical treatment, had their privacy violated, and were refused admittance to nursing homes and residential facilities.¹⁴ In addition, HIV-related stigma can have harmful effects on the perception and treatment of HIV-positive individuals by society, communities, families, and partners.^{11,15–17}

HIV-related stigma and discrimination are often associated with pre-existing fears, ignorance and misunderstanding about issues such as sexuality, gender, race, ethnicity, culture, and drug use.^{16,18–20} In the U.S., HIV-related stigma and discrimination are most closely related to negative thoughts surrounding homosexuality.^{16,19} This is because the HIV epidemic initially affected primarily gay men, and the belief that gay men are the primary risk group is still common in many communities.^{16,21,22} In addition, because HIV transmission is associated with stigmatized behaviors (e.g., men who have sex with men, men who have sex with men and women, having anonymous or multiple sex partners, and injection and non-injection drug use) and stigmatized groups (e.g., gay and bisexual men, sex workers, substance users), individuals with HIV disease are automatically presumed to have engaged in one or more of these behaviors or to be from one of these groups.

The manifestation of HIV-related stigma and discrimination is closely linked to the prevalence of homophobia in communities of color. The primary sources of homophobia include community and family norms, attitudes, and values. In the African American community, for example, homosexuality is seen as a taboo subject that clashes with race, gender role expectations, definitions of masculinity, community norms relating to sexuality, and is perceived of as sinful and unnatural.^{23–27} Homosexuality is also seen as a weakness or an embarrassment to the African American community.^{22,24} Similarly, in the Latino community, homosexuality is seen as a sign of weakness and is in conflict with family and community norms concerning what it means to be a man.^{15,26} For Latino gay men, homosexuality is thought to hurt or embarrass the family.^{28,29} Negative attitudes and beliefs about homosexuality often result in fear or reluctance among gay and bisexual men of color to identify as “gay” or to be “out” as a gay or bisexual person in their community.^{30,31} Fear of social repercussions due to sexual orientation has led many Latino and African American gay and bisexual men to identify as heterosexual, while secretly engaging in sex with men.^{11,25,29,32}

The pervasive negative attitudes towards HIV and homosexuality found in communities of color have contributed to a lack of participation in HIV prevention services by gay, bisexual, and heterosexual men of color. Latino and African American men, for example, may refuse to get tested for HIV because consenting to be tested is equated to admitting they have engaged in some stigmatized sexual behavior.^{32–34} Fear of being perceived as gay or bisexual may cause African American men to avoid expressing any concern about HIV or to avoid discussing condom use.²³ In addition, among African American men, using a condom is seen as a threat to masculine prowess,³⁵ or may be viewed as evidence of having sex outside the relationship or having a sexually transmitted infection.^{36,37} Latino and African American men who engage in sex with both men and women, but are not open about their bisexual behavior, may not use condoms with their male or female partners, thus creating a bridge for HIV transmission between gay men and heterosexual women.^{30,38–47} The discomfort of communities and families with issues of sexuality and sex, and the sometimes virulent homophobia emanating from some religious institutions, have hindered efforts to promote safer sex practices in many communities of color.^{23,24,35,48–50} In order to effectively address HIV prevention, programs must address HIV-related stigma, discrimination, and homophobia that can hinder and even prohibit utilization of effective programs.

In Los Angeles (L.A.) County, as well as other parts of the country, the need to address HIV-related social biases (stigma, discrimination, and homophobia) is of great concern as the epidemic continues to increase among gay and bisexual men of color and other stigmatized populations. In L.A., for example, men who have sex with men (MSM) remain the primary behavioral risk group impacted by HIV across all racial/ethnic groups.⁵¹ In addition, men of color made up the majority (76%) of new AIDS cases reported among men who have sex with men and women (MSM/W).⁵²

To assist HIV prevention providers in addressing these social biases, the L.A. County Department of Health Services, Office of AIDS Programs and Policy and the UCLA Center for HIV Identification, Prevention, and Treatment Services hosted an interactive two day symposium entitled, "Fighting Oppression: Preventing HIV Among MSM and MSM/W of Color." The symposium was held on June 16 and 17, 2004. Staff from HIV service programs throughout L.A. County that provide HIV prevention services in communities of color attended the symposium. As part of the registration process, individuals were asked to self-select into one of seven breakout groups that were organized by race/ethnicity and behavioral risk group. A total of 144 people participated in the symposium breakout groups and represented 43 HIV prevention programs.

This commentary highlights the suggested responses of HIV service providers to address HIV-related social biases in order to develop appropriate HIV prevention programs for Latino and African American gay and bisexual men in L.A.

SYMPOSIUM OUTCOMES

The perspectives and experiences of HIV service providers provide an important knowledge base for understanding and addressing HIV-related social biases. The manifestations of these social biases are that many Latino and African American gay and bisexual men will deny their sexual orientation, continue to engage in risky behaviors, and avoid utilizing HIV prevention services. The perspectives of providers underscore the need to consider the social and contextual factors of a community when designing and implementing HIV prevention programs for these men and offer five strategies that may help shape future HIV prevention efforts.

Address Social Biases Present in a Community

As part of a comprehensive HIV prevention effort, it is important to address the social biases present in a community or neighborhood that can hinder prevention activities in order to create an environment in which HIV prevention programs will work. In communities of color there is a need to address the sexual stigma against gay and bisexual men. This may require expanding prevention efforts to include activities that seek to create greater community awareness of sexual diversity, sexual identity, and HIV; activities might include locally sponsored community forums or workshops on these issues, participation by HIV prevention programs in local health fairs, participation by gay and lesbian groups in local cultural or community festivals, or the establishment of a gay/straight alliance to address HIV issues in a community. Previous research has suggested that increased public contact and exposure with stigmatized groups (gays and lesbians, ethnic minorities, mentally ill, homeless individuals, etc.) has been effective in reducing negative perceptions of these groups.^{53–59} HIV prevention programs should be implemented with consideration of the social and cultural norms surrounding issues of sexuality, sexual identity, gender role expectations, and masculinity that exist in the communities in which they are located. It is important that attempts to increase awareness of these issues be done at the community-level in order to have an impact among residents of the community.

Recast HIV Prevention in a Broader Context

There is a need to recast HIV prevention messages for Latino and African American gay and bisexual men in a broader context. HIV prevention messages should be integrated into a larger health initiative for men of color or in conjunction with other types of social services. The growing fatigue with HIV prevention messages or what is referred to as “HIV prevention burnout” has signaled a need to re-think our HIV prevention messages.^{60–66} The single focus on HIV is no longer sufficient or appropriate. Including HIV in a broader health context is already occurring in a few gay communities with a holistic gay men’s health movement that addresses multiple health problems of gay men, including HIV.⁶⁷ In addition, it was suggested by providers that HIV prevention interventions be expanded to include other salient issues of the target population. Recommendations from prevention researchers have included combining HIV prevention with other issues, such as integrating prevention with job training programs, housing programs, criminal justice programs, and empowerment programs.⁶⁸ Providing HIV prevention in a broader context, and in a more subtle way, may help decrease the stigma attached to the disease and increase participation in HIV prevention programs. As we look to the future, new programs should consider a much broader approach to HIV prevention that goes beyond sexual and substance abuse risk behaviors and integrates the larger social, health, and mental health issues affecting members of the target population.

Develop Culturally Appropriate Messages

For gay and bisexual men of color, new or revised prevention programs need to emphasize cultural appropriateness. Researchers have continuously identified cultural congruence as an important element in developing intervention activities, framing prevention messages, and disseminating information in Latino and African American communities.^{23,29,68,69} Specific recommendations from symposium participants included using elements of Latino or African American culture in materials and activities, integrating cultural pride into prevention messages, and building on the strengths of the community.

Explore New Methods and Places for Delivering Prevention Messages

Prevention programs must explore new modalities and venues for delivering HIV prevention messages that are appropriate for Latino and African American gay and bisexual men and the communities in which they live. Many of these men do not identify as gay or do not live in gay-dominated communities nor frequent places and events that are gay-identified. Therefore, HIV prevention interventions targeting these men will require increased flexibility in the mechanisms used in delivering prevention messages. Emphasis should be given to methods and venues that are non-stigmatizing. Recommendations from providers for ways to deliver messages included using local neighborhood media (e.g., neighborhood newspapers, local cable channels, outdoor advertising), with local role models and opinion leaders delivering the prevention messages. Specific recommendations of different venues to undertake HIV prevention activities included: churches, barber shops, beauty salons, jails and prisons, social service agencies, health clubs, schools, neighborhood centers, non-gay settings and non-HIV community events. Needle exchange programs are also important venues to target.

The church is one of the main institutions in Latino and African American communities with the ability to influence community norms and attitudes towards HIV prevention. The church has also been a major obstacle in the battle against the spread of HIV, particularly among gay and bisexual men. The prevalence of homophobia in many black churches, for example, has continued to perpetuate negative views of gay and bisexual men, and by extension, men living with HIV/AIDS that has impeded their ability to engage in HIV prevention activities with the most at-risk populations.⁷⁰ In addition, the inability or refusal of black clergy to discuss sexual issues, particularly behaviors associated with HIV transmission (anal sex, bisexuality, homosexuality) has hindered their ability to provide effective HIV prevention information to

members of their congregation.^{22,71,72} The Catholic Church's condemnation of homosexuality, ban against the use of condoms, and insistence on abstinence has made it impossible for the Catholic Church to work effectively to suppress the spread of HIV, particularly among Catholic Latino populations.⁷³ In contrast, some black churches have taken a more active role in HIV prevention efforts. Probably the best examples are churches involved in the annual Black Church Week of Prayer for the Healing of AIDS, which encourages churches to develop AIDS prevention programs, establish HIV testing facilities, and set up HIV/AIDS ministries in the church and community.⁷⁴ In communities of color some churches stand out as promising institutions to help in preventing the spread of HIV by working to overcome ignorance and stigma, while others will remain as roadblocks to prevention efforts.

Beauty salons and barber shops are other non-traditional venues that have already begun to play a role in HIV prevention in many African American communities and may be a model for Latino communities.⁷⁵⁻⁷⁷ These businesses have long been places where information is exchanged on a variety of topics and as a result lend themselves well to HIV prevention activities, such as information dissemination, condom distribution, and HIV prevention discussions by staff trained to provide such information. Examples of these types of efforts can be found in cities like Nashville, TN, Wilmington, NC, and Charleston, SC. These non-traditional settings help remove some of the stigma attached to HIV that might otherwise be experienced in a more traditional HIV prevention program venue, that is, one clearly identified and known in the community as an HIV/AIDS or gay organization.

Correctional facilities were identified as another venue for HIV prevention efforts targeting men of color. Jails and prisons are particularly important sites given the high incidence of sexual activity and drug use in these facilities and their link to HIV transmission in the community.⁷⁸ One study, for example, found that one in five men reported a forced or pressured sex act while incarcerated, and about one in ten inmates reported that they had been raped.⁷⁹ According to participants in our symposium, upon release from correctional facilities, men are not likely to disclose to partners any sexual behavior while incarcerated, due to shame of being raped or because of experimentation with homosexual behaviors. This lack of disclosure may place female and male partners at risk for exposure to HIV and other infectious diseases (e.g., hepatitis and other sexually transmitted infections). The suggestions for prevention activities in prisons and jails included compulsory HIV testing upon entering a facility, risk reduction education workshops and HIV testing prior to release, and linkages to community services for post-incarceration HIV prevention services. Condom distribution in correctional facilities is also needed to prevent infections while incarcerated.

Broaden Target of Prevention Messages

For HIV prevention services to work, it will be necessary for programs to broaden their targets to include not only at-risk populations, but also service providers and the community at-large. Symposium participants recommended in-service trainings of service providers on issues of culture, stigma, and sexuality as they relate to the provision of HIV prevention services. This may help address the limited knowledge of these issues that is endemic in many social service, institutional, and health care settings in Latino and African American communities. In addition, community level interventions (e.g., social marketing campaigns) are needed to help challenge community norms that stigmatize HIV, homosexuality, and substance abuse in order to create an environment in which prevention services will work.

CONCLUSION

Stopping the spread of HIV among Latino and African American gay and bisexual men in the communities in which they live is a difficult and daunting task. HIV disease raises uncomfortable and sensitive issues around sexual identity, homosexual and bisexual behavior,

and substance use, which are difficult to talk about in any context. Communities must begin to establish an open dialogue about sexuality and drug use if HIV prevention programs are to be successful with gay and bisexual men. Community leaders along with HIV and non-HIV organizations can have a significant impact in introducing and maintaining this dialogue. Latino and African American communities must create environments where gay and bisexual men feel comfortable accessing prevention services without fear of stigma, rejection, or judgment.

References

1. AIDS Action. *Stigma and Prevention* Fact Sheet. Washington, DC: AIDS Action; 2001.
2. AIDS Alert, American Health Consultants. Fear of disclosure and popular stigmas contribute to bad outcomes [abstract]. *AIDS Alert* 2001;16(2):13. [PubMed: 15446220]
3. Fortenberry JD, McFarlane M, Bleakley A, et al. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002;92(3):378–380. [PubMed: 11867314]
4. Gerbert B, Maguire BT, Bleecker T, Coates TJ, McPhee SJ. Primary care physicians and AIDS: Attitudinal and structural barriers to care. *JAMA* 1991;266:2837–2842. [PubMed: 1942450]
5. Goldin CS. Stigmatization and AIDS: Critical issues in public health. *Social Sci Med* 1994;39:1359–1366.
6. Herek GM. AIDS and stigma. *Am Behav Sci* 1999;42(7):1106–1116.
7. Herek GM, Capitanio JP, Widaman KF. Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychol* 2003;22(5):533–540. [PubMed: 14570537]
8. UNAIDS. *HIV/AIDS stigma and discrimination: A conceptual framework and basis for action. World AIDS Campaign 2002–2003* Geneva, Switzerland: UNAIDS; 2002: 7–9.
9. Valdiserri RO. HIV/AIDS stigma: an impediment to public health. *Am J Public Health* 2002;92(3): 341–2. [PubMed: 11867303]
10. Piot P. Report by the Executive Director. Program Coordinating Board. Joint United Nations Program on AIDS. Rio de Janeiro: UNAIDS; 2000.
11. Malebranche DJ. Black men who have sex with men and the HIV epidemic: next steps for public health. *Am J Public Health* 2003;93(6):862–865. [PubMed: 12773340]
12. Herek GM. Illness, stigma, and AIDS. In: *Psychological Aspects of Serious Illness* Costa P and VendenBos GR, eds. Washington, DC: American Psychological Association; 1990:103–150.
13. Higgs L. AIDS forum presents mixed report. *Courier News*: March 9, 2003. Available from: CDC National Prevention Information Network: News Record #37224.
14. Reuters. AIDS discrimination in US is widespread. Reuters News Service: November 13, 2003. Available from: CDC National Prevention Information Network: News Record #39087.
15. Díaz RM, Ayala G. *Social discrimination and health: The case of Latino gay men and HIV risk* New York: Policy Institute of the National Gay and Lesbian Task Force; 2001.
16. Herek GM, Capitanio JP. AIDS stigma and sexual prejudice. *Am Behav Sci* 1999;42(7):1130–1147.
17. Herek GM, Glunt EK. An epidemic of stigma: Public reactions to AIDS. *Am Psychol* 1998;43:886–892. [PubMed: 3063145]
18. Herek GM, Capitanio JP, Widaman KF. HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991–1999. *Am J Public Health* 2002;92(3):371–377. [PubMed: 11867313]
19. Public Media Center. *The Impact of Homophobia and Other Social Biases on AIDS* San Francisco, CA: Public Media Center; 1995.
20. Parker R, Aggleton P. HIV/AIDS-related stigma and discrimination: A conceptual framework and an agenda for action. Washington DC: Population Council-Horizons Program; 2002.
21. Herbert H. A black AIDS epidemic. *New York Times*: June 4, 2001. Available from: CDC National Prevention Information Network: News Record #32554.
22. Wittenauer C. City Health Department, churches inform blacks about rise in HIV cases. Associated Press: August 9, 2002. Available from: CDC National Prevention Information Network: News Record #38362.

23. Stokes JP, Peterson JL. Homophobia, self-esteem, and risk for HIV among African American men who have sex with men. *AIDS Educ Prev* 1998;10(3):278–292. [PubMed: 9642425]
24. Tucker C. In AIDS fight, homophobia hinders blacks. *Atlanta Constitution* June 17, 2001. Available from: CDC National Prevention Information Network: News Record #3267.
25. Vargas JA. HIV-positive, without a clue black men's hidden sex lives imperiling female partners. *Washington Post*: August 4, 2003. Available from: CDC National Prevention Information Network: News Record #38309.
26. Greene B. Ethnic-minority lesbians and gay men: mental health and treatment issues. *J Consult Clin Psychol* 1994;62(2):243–251. [PubMed: 8201060]
27. Herek GM, Capitano JP. Black heterosexuals' attitudes toward lesbians and gay men in the United States. *Journal Sex Res* 1995;32(2):95–105.
28. Díaz R. Latino gay men and HIV: Culture, sexuality and risk behavior. Boston: Routledge Kegan Paul; 1998.
29. Díaz RM, Ayala G, Bein E, Henne J, Marin BV. The impact of homophobia, poverty and racism on the mental health of Latino gay and bisexual men: Findings from a probability sample in three U.S. cities. *Am J Public Health* 2001;91(6):927–932. [PubMed: 11392936]
30. HIV/STD Risks in young men who have sex with men who do not disclose their sexual orientation—six U. S. cities, 1994–2000. *MMWR* 2003;52(05):81–86. [PubMed: 12588004]
31. Kenamer JD, Honnold J, Bradford J, Hendricks M. Differences in disclosure of sexuality among African American and White gay/bisexual men: implications for HIV/AIDS prevention. *AIDS Educ Prev* 2000;12(6):519–531. [PubMed: 11220504]
32. Londono E. Aided by silence, HIV grows among Latinos. *Dallas Morning News* October 14, 2003. Available from: CDC National Prevention Information Network: News Record #38837.
33. Moore B. Distrust, stigma hinder fight. *St. Petersburg Times*: July 8, 2001. Available from: CDC National Prevention Information Network: News Record #32854.
34. Robinson A. An in your face strategy teaches Latinos about HIV. *Miami Herald*: October 30, 2003. Available from: National Prevention Information Network: News Record #38992.
35. Rose T. The new AIDS fight—Race, sex and stigmas. *New York Times*: March 1, 2003. Available from: CDC National Prevention Information Network: News Record #37168.
36. Thorburn S, Harvey SM, Ryan EA. HIV prevention heuristics and condom use among African-Americans at risk for HIV. *AIDS Care* 2005;17(3):335–344. [PubMed: 15832881]
37. Reeves J. Study finds men unlikely to use condoms despite disease. Associated Press: January 23, 2004. Available from: National Prevention Information Network: News Record #39619.
38. Wohl AR, Johnson DF, Lu S, et al. HIV risk behaviors among African American men in Los Angeles County who self-identify as heterosexual. *J Acquir Immune Defic Syndr* 2002;31(3):354–360. [PubMed: 12439213]
39. Stokes J, McKirnan DJ, Doll L, Burzette RG. Female partners of bisexual men. *Psychol Women Quart* 1996;20:267–284.
40. McKirnan DJ, Stokes JP, Doll L, Burzette RG. Bisexually active men: social characteristics and sexual behavior. *J Sex Res* 1995;32:64–75.
41. Villarosa L. AIDS fears grow for black women. *New York Times*: April 5, 2004. Available from: CDC National Prevention Information Network: News Record #40139.
42. Sternberg S. The danger of living “down low”; black men who hide their bisexuality can put women at risk. *USA Today*: March 15, 2001. Available from: CDC National Prevention Information Network: News Record #31881.
43. Staples GB. The deadly secret. *Atlanta Journal Constitution*: July 18, 2001. Available from: CDC National Prevention Information Network: News Record #32918.
44. Villarosa L. AIDS education is aimed “down low.” *New York Times*: April 3, 2001. Available from: CDC National Prevention Information Network: News Record #31991.
45. Agronick G, O'Donnell L, Stueve A, Doval AS, Duran R, Vargo S. Sexual behaviors and risks among bisexually- and gay-identified young Latino men. *AIDS Behav* 2004;8(2):185–197. [PubMed: 15187480]

46. Poppen PJ, Reisen CA, Zea MC, Bianchi FT, Echeverry JJ. Predictors of unprotected anal intercourse among HIV-positive Latino gay and bisexual men. *AIDS Behav* 2004;8(4):379–389. [PubMed: 15690111]
47. Montgomery JP, Mokotoff ED, Gentry AC, Blair JM. The extent of bisexual behaviour in HIV-infected men and implications for transmission to their female sex partners. *AIDS Care* 2003;15(6): 829–837. [PubMed: 14617504]
48. AIDS Project Rhode Island. Homosexualidad y bisexualidad entre hombres Latinos. *Quipu*: July 5, 1993. Available from: CDC National Prevention Information Network: News Record #16036.
49. Fraser D. BCA finds black churches can help quietly break AIDS taboos. *Bay Area Reporter*: June 14, 2001. Available from: CDC National Prevention Information Network: News Record #32786.
50. Gonzalez FJ. Why are Latino gay and bisexual men at risk? *Focus* 1995;10:1–4. [PubMed: 11362583]
51. HIV Epidemiology Program, Los Angeles County Department of Health Services. HIV/AIDS Surveillance Summary, January, 2004. Los Angeles: Los Angeles County Department of Health Services; 2004: 1–28.
52. HIV Epidemiology Program, Los Angeles County Department of Health Services. Special data run. Los Angeles: Los Angeles County Department of Health Services; 2002.
53. Alexander LA, Link BG. The impact of contact on stigmatising attitudes toward people with mental illness. *J Mental Health* 2003;12(3):271–289.
54. Desforges DM, Lord CG, Ramsey SL, et al. Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *J Pers Soc Psychol* 1991;60(4):531–544. [PubMed: 2037965]
55. Anderssen N. Does contact with lesbians and gays lead to friendlier attitudes? A two year longitudinal study. *J Comm Appl Social Psychol* 2002;12:124–136.
56. Allport GW. *The Resolution of Intergroup Tensions* Oxford, England: Conference of Christians and Jews; 1952: 1–49 (pamphlet).
57. Couture SM, Penn DL. Interpersonal contact and the stigma of mental illness: A review of the literature. *J Mental Health* 2003;12(3):291–305.
58. Bos AER, Kok G, Dijkster AJ. Public reactions to people with HIV/AIDS in the Netherlands. *AIDS Educ Prev* 2001;13(3):219–228. [PubMed: 11459358]
59. Mayville E, Penn DL. Changing societal attitudes toward persons with severe mental illness. *Cognit Behav Pract* 1998;5(2):241–253.
60. Centers for Disease Control and Prevention. Taking action to combat increases in STDs and HIV risk among men who have sex with men. Atlanta, GA: CDC; 2001. Available at: http://www.cdc.gov/nchstp/od/news/92288_AED_CDC_report-0427c.pdf Accessed October 21, 2003.
61. Malcolm A, Aggleton P, Bronfman M, Galvao J, Mane P, Verrall J. HIV-related stigmatization and discrimination: Its forms and contexts. *Critical Pub Health* 1998;8(4):347–370.
62. Fruchter J. Colorado looks for new way to educate, avoid “Safer Sex Burnout.” *Colorado Daily*: June 4, 2002. Available from: CDC National Prevention Information Network: News Record #35254.
63. King W. Dramatic surge seen in local HIV cases. *Seattle Times*: June 4, 2003. Available from: CDC National Prevention Information Network: News Record #37836.
64. Rhor M. Syphilis outbreak troubles officials. *Miami Herald* March 23, 2003. Available from: CDC National Prevention Information Network: News Record #37287.
65. Ritter J. Fresh rise in HIV rate rings alarms: Prevention burnout and a return of risky sexual behavior among gay men. *USA Today*: July 31, 2000. Available from: CDC National Prevention Information Network: News Record #30430.
66. U.S. Dept. of Health and Human Services, Health Resources and Services Administration. *Prevention is treatment: Prevention with positives in clinical care* Washington, DC: U.S. Department of Health and Human Services; 2003. Available at: <http://www.hab.hrsa.gov/publications/march2003.htm> Accessed October 21, 2003.
67. Heredia C. Serving body and soul with music, games and art, magnet adds a touch of fun to health checkups. *San Francisco Chronicle* September 28, 2003. Available from: CDC National Prevention Information Network: News Record #38747.

68. Icard LD, Schilling RF, El-Bassel N, Young D. Preventing AIDS among black gay men and black gay and heterosexual male intravenous drug users. *Social Work* 1992;37:440–445. [PubMed: 1411710]
69. Fernandez MI, Perrino T, Bowen GS, Royal S, Varga L. Repeat HIV testing among Hispanic men who have sex with men—a sign of risk, prevention, or reassurance? *AIDS Educ Prev* 2003;15(supp A):105–116. [PubMed: 12630603]
70. Fullilove MT, Fullilove RE. Stigma as an obstacle to AIDS action. *Am Behav Scientist* 1999;42:1117–1129.
71. Coyne-Beasley T, Schoenbach VJ. The African-American church: a potential forum for adolescent comprehensive sexuality education. *J Adolesc Health* 2000;26(4):289–294. [PubMed: 10734276]
72. Kilbane K. Churches use prayer, education to fight disease. *Fort Wayne News Sentinel*: March 5, 2005. Available from: CDC National Prevention Information Network: News Record #42491.
73. Catholic churches say condoms don't stop AIDS. Reuters: October 9, 2003. Available from: CDC National Prevention Information Network: News Record #38790.
74. Balm in Gilead, Inc. The Black Church Week of Prayer. Available at: <http://www.balmingilead.org/programs/weekofprayer2005/welcome.asp> Accessed April 28, 2005.
75. Wadhwani A. Salon owners help make blacks aware of HIV/AIDS. *Tennessean*: March 12, 2004. Available from: CDC National Prevention Information Network: News Record #39963.
76. Brown R. AIDS message hits salons. *Wilmington News Journal*: December 16, 2004. Available from: CDC National Prevention Information Network: News Record #42031.
77. Minis W. Salons, churches reach out to educate. *Post and Courier*: June 23, 2003. Available from: CDC National Prevention Information Network: News Record #38020.
78. Clemetson L. Links between prison and AIDS affecting blacks inside and out. *New York Times*: August 6, 2004. Available from: CDC National Prevention Information Network: News Record #41029.
79. Stop Prisoner Rape. The Basics on Rape Behind Bars. Available at: http://www.spr.org/en/doc_01_factsheet.html Accessed April 28, 2005.