

An American Tragedy:  
Social Factors Behind the HIV/AIDS Epidemic in the United States

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Anthropology Honors Thesis  
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April 17, 2012

## Acknowledgements

I want to thank my thesis advisors, Gillian Feeley-Harnik and Erik Mueggler for their advice and insight throughout this semester, and my “Thesis ‘12” ladies for providing support (and food) during each of our weekly seminars. This process would have been exponentially harder without you all. Thank you.

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## Introduction

I am writing this thesis for my mother, the most influential person in my life. She left a job at the Rockefeller Foundation in 2003 to start her own global nonprofit organization, working with communities around the globe, focusing on African nations. She travels internationally approximately four months of the year, helping people advocate for themselves for social change. Her work includes clean water initiatives, vaccination campaigns, education for females, and HIV/AIDS prevention. I will never forget the moment she told me “After visiting clinics and seeing AIDS patients die, I would rather be shot in the face than infected with HIV.” This is one of the most powerful statements I have ever heard, and it shaped the person that I am now. Hearing words like this from my mother put the fear of HIV in me, so I decided to educate myself about the virus in order to be an advocate for prevention.

As a heterosexual Black female, I realize that HIV is a real threat to my life. AIDS-related causes are the leading cause of death among African American women between the ages of 25 and 44 (McBride Murry 2011:1147). By nature of being a Black American, I will know somebody in my lifetime infected with, or who dies from, HIV/AIDS. According to the Centers for Disease Control and Prevention, 1 in 32 Black women and 1 in 16 Black men will become infected with HIV (CDC 2012). Knowing this, how can I *not* be an advocate for prevention?

When I first decided to write an honors thesis, I knew that I wanted to write about HIV/AIDS in some capacity. Initially I wanted to write about a topic that is little discussed, so I decided to write about women in Rwanda who were mass raped during the 1994 genocide and subsequently infected with HIV. After some time, however, I realized how difficult this project would be. I would not be able to take several weeks off of school to travel to Rwanda, communicating with the women would be hard because of the language barrier, and moreover,

many of the women infected with HIV in 1994 would have already passed away due to complications of the virus. When I finally came to these conclusions, I had to think of another thesis idea.

I thought for a while about what interests me about the HIV/AIDS epidemic, and then decided to write about HIV prevention programs. I volunteered with an HIV/AIDS-related nonprofit organization, taking field notes and observing one of its outreach programs. After a while, however, I realized that I very much disagreed with the program and did not want to spend my entire semester doing something that I was not passionate about. I had to go back to the drawing board, finally for the last time.

When thinking about what interests me about the HIV/AIDS epidemic, I had one lingering question in my mind: why do people still get infected with HIV? There are commercials, nonprofit organizations devoted to prevention, even classes about the virus. Why then, are so many people still getting infected? Why are there over one million AIDS-related deaths globally each year? It cannot be because of a lack of information or about the biology of the virus itself. I decided to base my thesis around the question, “what are the social and/or political factors contributing to the HIV/AIDS epidemic, despite the spread of knowledge about the epidemic?”

At first I thought about focusing on HIV/AIDS in the Black community in the United States, but then I had a mind-blowing conversation with one of my roommates. She told me that her friends from Nashville, Tennessee do not think that they can get infected with HIV because they are not homosexual. This conversation made me realize that I need to focus on the entire adult population, not just Black Americans. That said, however, a good portion of my research has focused on Black Americans for two reasons. One reason is that Black people are becoming

increasingly affected by the HIV/AIDS epidemic, and the other is that I am a Black American, so I am especially passionate about issues relating to this community. This is a subject that is very close to my heart. I have seen first hand how structural violence and systemic injustice have ravaged Black America, and I want to prevent HIV/AIDS from causing any more damage.

I want to figure out the social factors that contribute to the HIV/AIDS epidemic, and more importantly, the best ways in which to prevent the spread. My hope is that in figuring out the social factors and understanding the communities most infected, I can begin to formulate effective ideas for prevention.

## Methods

I hoped that my interviews would provide a rich source of information, but I was not able to get the depth that I wanted from my informants. That said, this thesis will comprise an expansive literature review, supported by commentary from my personal experience and from my informants. The literature review provides evidence for my existing beliefs, as well as a more diverse body of opinions.

My interviews took place between December 2011 and March 2012 on the University of Michigan campus. The length of the interviews varied from fifteen to forty-five minutes. It is imperative that I point out that all of my informants were either students currently enrolled in four-year universities, or alumni of four-year universities. That said, I do not feel that the opinions of my informants are representative of the American adult population at large. If I were to continue this research, I would include informants who were not university students or alumni.

## Origins of HIV/AIDS

According to scientists, the human immunodeficiency virus (HIV) originated in central Africa, where it spread to Haiti, then to the United States. In an account about the beginning of the HIV/AIDS epidemic, Jacques Pepin explains how HIV spread from its origin in Central Africa to the United States. Pepin explains that hunters in Central Africa, specifically the Belgian Congo and Cameroon, were infected with HIV when hunting chimpanzees infected with simian immunodeficiency virus, SIV (Pepin 2011:23). As chimpanzees have 98 to 99% of the same genome as humans (Pepin 2011:18), the SIV was easily able to cross species and turn into HIV in human beings. When hunters cut up chimpanzee meat, some of their blood was exchanged, and the SIV-infected chimpanzees spread the virus to humans, in the form of HIV. According to Pepin, 80 adults living in central Africa had been exposed to SIV, and the transmission rate was between one and three percent (Pepin 2011:49). While 80 individuals does not sound like that many, there were accelerants which enabled the spread of HIV from a few infected individuals to millions globally.

One of these accelerants was the prostitution that resulted from urbanization of the Belgian colonies, specifically the cities of Brazzaville and Léopoldville (Pepin 2011:69). The Belgian colonizers were extremely strict, and restricted the migration of women into the colonies; the colonies were mainly for men to mine (Pepin 2011:71). The Belgian colonizers introduced road systems, which enabled the migration of prostitutes into colonial cities, starting as early as the 1920s (Pepin 2011:93). Traditionally there were not many opportunities for women in these African cultures, so prostitution allowed the women a chance for freedom and economic independence. Because the colonial cities had such a gender imbalance and were



overwhelmingly comprised of males, the prostitutes could have a lucrative business (Pepin 2011:76). According to this theory, a hunter infected with HIV had sex with a prostitute, which enabled the spread of the virus within the population.

I must point out that I find some fault with this theory, as it represents the woman as a vector for the virus, responsible for spreading this deadly agent. Too often women are blamed for spreading HIV.

With that said, however, the history of the HIV epidemic continues. According to Pepin, one of the legacies of colonization was the establishment of a medical system. Both the French and the Belgian colonizers implemented a series of mass immunizations and injectable drug treatments for diseases such as malaria, leprosy, and syphilis, among others (Pepin 2011:119). The colonizers also administered treatment for sexually transmitted diseases (STDs) to the prostitutes (Pepin 2011:161). The problem with these campaigns, however, is that the medical practitioners re-used the syringes (Pepin 2011:164). Two factors of these medical brigades are important: the colonizers wanted to treat and inoculate the African subjects to protect themselves from infectious agents; and the medical campaigns, which were supposed to prevent disease, played a role in the spread of HIV. In their attempt to save individuals from disease, the colonizers contributed to one of the worst epidemics to date.

I have explained how HIV spread within Central Africa, but still the question remains as to how the virus spread to other continents. Theory holds that in the post-independence period, many Europeans fled, leaving the colonies without adequate leaders. The Congo asked the United Nations for foreign aid, and received technical assistants, including about 1,000 from Haiti in 1960 (Pepin 2011:187-188). According to Pepin, only one Haitian became infected with

HIV while in the Congo, but the presence of a blood bank, as well as sex tourism to the island, allowed the virus to spread to the United States (Pepin 2011:197).

The blood bank, Hemo-Caribbean, reportedly exported 6,000 liters of blood plasma to the United States each month (Pepin 2011:201). This posed a problem for two reasons: the re-usage of syringes enabled the spread of HIV within Haiti; and the sale of infected plasma encouraged the spread of the virus to the United States. According to Pepin, the blood plasma sold to the United States was used in blood products for hemophiliacs, one of the early risk groups.

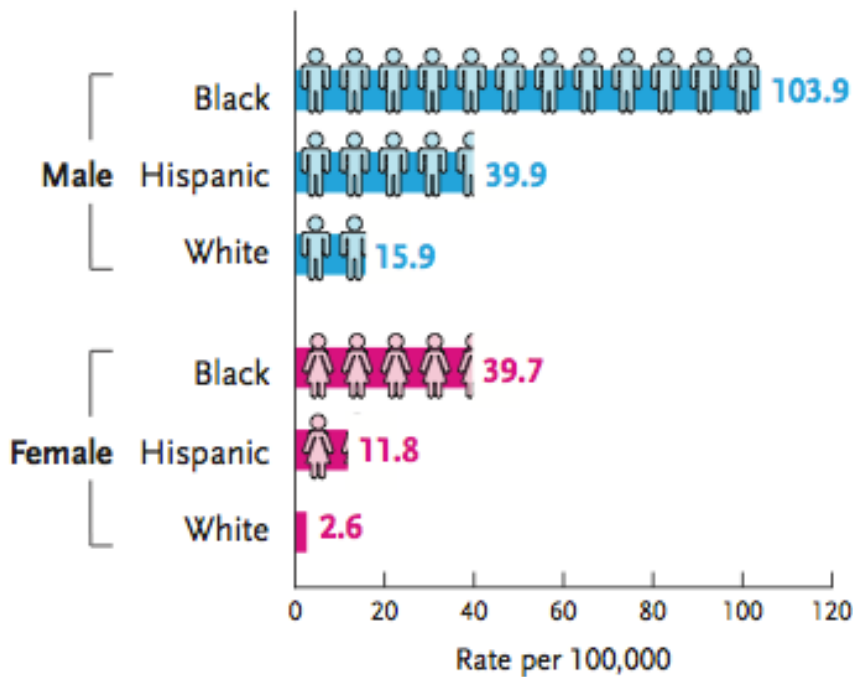
Pepin's theory suggests that Americans were infected with HIV through sex tourism in Haiti, as well as through infected blood products. When AIDS was first seen in the United States, it was amongst homosexual middle-class, white men, some of whom supposedly went on these sex tourism trips. These men were infected with illnesses such as pneumocystis pneumonia, a rare form of pneumonia that suggested a compromised immune system, and Kaposi Sarcoma, a skin cancer usually found in elderly men. The first cases were seen in Los Angeles, San Francisco, and New York City, areas of the country with large enclaves of gay men. The first articles about the virus in 1981 called it "Gay-Related Immune Deficiency" or GRID.

Over the course of a few years, however, the new virus began to be seen in other populations, including intravenous drugs users and hemophiliacs who had received tainted blood products. At this time, scientists realized that HIV was spread through bodily fluids, including blood, semen, and vaginal secretions. It is important to note that it was not until non-marginalized sectors of the population, including newborn children and women recipients of blood transfusion, started getting infected did researchers or the government pay much attention

to the virus. In 1982 the term AIDS, Acquired Immune Deficiency Syndrome, was coined, and in 1987 the Human Immunodeficiency Virus, HIV, was identified as the infecting agent.

Presently in the United States, men who have sex with men (MSM) and Black people are over-represented among HIV/AIDS cases. While the rates remain stable for MSM, they are increasing in the Black community. [See figure 1 below].

**Figure 7: Estimated Rate of New HIV Infections, 2009, by Gender and Race/Ethnicity**



[Figure 1 from the Centers for Disease Control and Prevention 2011. Estimates of New HIV Infections in the United States, 2006-2009]

This chart shows that Black males constitute the group with the highest number of new HIV infections in 2009. This has negative implications for the Black American population.

HIV/AIDS still disproportionately affects marginalized populations in the United States, especially men who have sex with men<sup>1</sup> (MSM), Black people, intravenous drug users, and incarcerated individuals. In this chapter I am going to explain the factors that leave these populations more vulnerable to HIV infection than others.

### **Men Who Have Sex with Men**

By 2005, over 550,000 people in the United States had died of HIV infection. 300,669 of these deaths were in men who have sex with men (Sullivan and Wolitski 2008:220). There are several factors that make MSM vulnerable to HIV infection. One widespread theory is that the first AIDS cases occurred soon after the gay liberation movement, a time during which homosexual men and women celebrated “coming out” and were having a lot of sex to make up for years of repressed sexual desires (David M. Halperin lecture 2012). Jeffrey Escoffier writes:

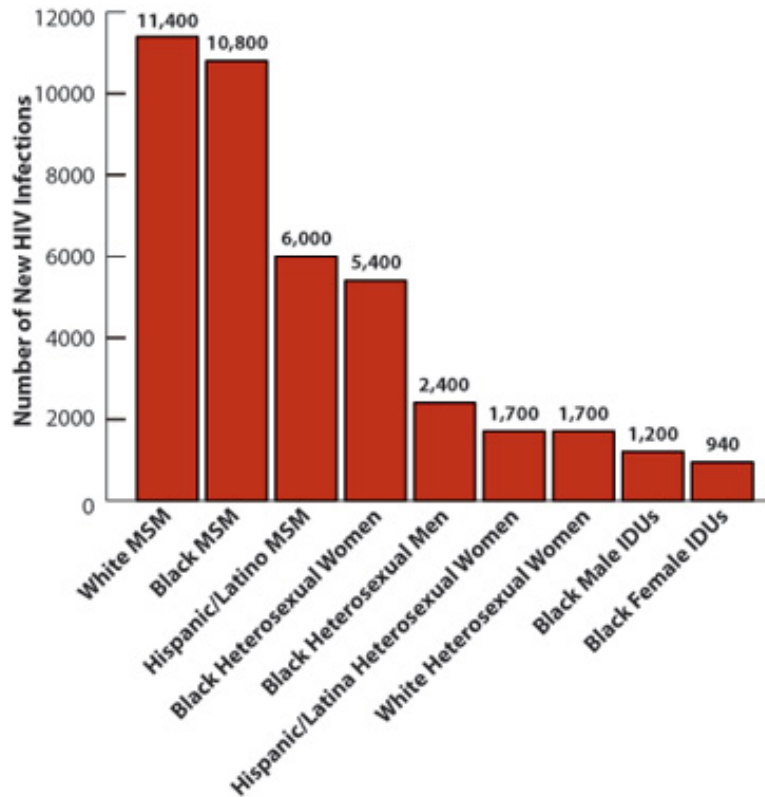
In the mid-seventies among gay intellectuals, particularly those who had been active in the anti-war movement and the new left, there was a movement to explore the “gay experience” in a way that modeled on black intellectuals’ recovery of black culture and history in order to reclaim the historical and cultural experience of homosexuals (Escoffier 1998:189).

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<sup>1</sup> The phrase “men who have sex with men” is used because not all of these men identify as homosexual.

When the first AIDS cases were reported, homosexual men were celebrating their sexual liberation; the presence of bathhouses in cities across the country was not uncommon. In these bathhouses, thousands of men had unprotected sex with strangers. While these facts may be true, I am skeptical to jump on this bandwagon because it seems to be placing the blame on a specific sector of the population without concrete evidence. I discussed briefly with Anthropology professor Gayle Rubin about this topic, who said that blaming the gay sexual revolution “is like blaming schools and education for epidemics of the flu” (email, March 21, 2012). The 1970s were a time of liberality in general, and I feel it is unfair to blame the homosexual community for the spread of HIV/AIDS.

A factor that I do believe in, however, is the biological risk of homosexual sex. HIV is transmitted more efficiently through anal intercourse than through vaginal intercourse. According to Sullivan and Wolitski, “the per-episode risk of transmission from receptive anal intercourse is five times greater than the risk from receptive vaginal intercourse” (2008:220). Although MSM created “safer sex” guidelines during the 1980s, this population continues to constitute the highest risk population. [See figure 2].



[Figure 2 from the Centers for Disease Control and Prevention: Estimates of New HIV Infections in the United States, 2009, for the Most-Affected Subpopulations].

As you can see, White MSM continue to make up the highest number of new infections, thirty years into the epidemic. This bar chart shows that marginalized populations, such as MSM, racial minorities, and injection drug users (IDUs), are still very affected by HIV. What is interesting here is that HIV infections are increasing amongst women of all races, and are even more numerous than infections in IDUs. The dynamic of the HIV/AIDS epidemic is changing in the United States, and is becoming increasingly more minority and women-centered. I will return to this point later in the thesis.

Seeing their peers die from AIDS, gay men became activists and created “safer sex” initiatives that decreased the number of infections through the late 1980s. Despite the effort of

gay men in the 1980s, the incidence rates (the number of new HIV infections) for MSM have increased in recent years, however.

One reason behind the increasing incidence of HIV is that advances in treatment have led to apathy amongst some MSM, and members of the general population at large, in the United States. Highly active antiretroviral therapy (HAART) was introduced in 1996, and has enabled thousands of HIV positive persons a chance to survive. Sullivan and Wolitski write:

Beliefs about HIV, specifically beliefs about susceptibility to infection and the severity of HIV infection, may influence the adoption of preventative behaviors...some men believe that HAART reduces the likelihood that an HIV-infected sex partner will transmit HIV, or they believe that the severity of HIV infection will be less because of the availability of HAART. Optimistic beliefs about HAART perhaps may be held by as many as 25% of MSM and have been associated with higher risk sex behaviors in this population (2008:227).

The creation of HIV treatment can be seen as a double-edged sword: antiretroviral drugs (ARVs) have increased lifespans of HIV infected individuals, but have also led to a sense of complacency about the virus.

Younger MSM are being infected at higher rates today. As previously stated, gay men in the 1980s witnessed their friends and peers die from AIDS; young MSM today have not had the same experience, and therefore are not as militant in prevention. One of my informants echoed

this sentiment saying “people don’t realize that something like that exists until they meet someone who has it, or they see it in real life and see what it can do.” In today’s world, HIV/AIDS is not as widely discussed as it was at the beginning of the epidemic. Many young MSM, and young people in general for that matter, do not feel the sense of urgency that MSM did during the 1980s, so HIV incidence among this population is increasing.

Although MSM were the forerunners and created safe sex information, what exists are political economy of health and structural injustice.

### **Black Americans**

Black Americans account for 44% of all new HIV infections (Centers for Disease Control and Prevention 2009). AIDS is the leading cause of death among Black women aged 25-44 years, and in some areas of the rural South, Black women account for 72% of all reported cases (Robert Fullilove 2006:11). The key reasons that HIV disproportionately affects Black people are: poverty; incarceration; and intravenous drug use.

Poverty, and the unstable housing as a result, is the major factor behind the HIV epidemic in Black Americans. Black people in the United States tend to live in resource-poor, segregated areas of extreme poverty, where crime flourishes. Due to the dangerous surroundings, individuals are less likely to travel long distances to access medical care (Fullilove 2006:18). Further, when individuals have unstable housing, adherence to medical treatment is more difficult. One reason adherence is more difficult is because some HIV drugs need to be refrigerated. This is a problem for HIV infected individuals who are homeless or who move from home to home, and is a factor in the spread of HIV as well as AIDS-related deaths.



Additionally, even those drugs that do not need to be refrigerated need to be taken at the same time every day, some several times a day. If an individual is homeless, there are other occurrences that make taking these drugs difficult, such as searching for food or shelter, which take precedence over taking pills.

Adherence to HIV medication is critical, because failure to do so can lead to drug resistance, a major problem among HIV positive people that leads to full progression of AIDS, and inevitably, death. The best drug regimen to fight HIV infection is a combination of at least three drugs, each which inhibit a step of the HIV replication cycle. If an individual neglects to take one drug, for example, that step of the lifecycle can occur, allowing HIV to reproduce inside the body. This is especially true for the reverse transcription of the virus, when the virus turns the host cell RNA into viral DNA, a phase of the cycle that is extremely prone to mutation. If mutation occurs in this step, an entirely new strain of the virus can be reproduced in the person's body, meaning that the drugs are no longer combative.

Evidence of the problems that poverty causes HIV infected individuals is the 2010 documentary called *The Other City*. Filmmaker Susan Koch follows the lives of young people in Washington D.C. living with HIV or AIDS. One Black woman, J'Mia, stands out. She is a single mother with three kids who relies on public housing, but was told that she would no longer be able to stay in her current apartment because she was making "too much" money. I put "too much" in quotations because J'Mia was still living *under* the poverty line, but was not poor enough to qualify for welfare services. In an interview she said, "I'm gonna do whatever I have to do to feed my kids. If that means sleeping with a man so my kids and I have a place to stay for a week, I'm gonna sleep with him." This young woman tells the reality of HIV infected persons with unstable housing conditions; they are going to do whatever it takes to survive, even

if it means having sex with someone. As a result of the stigma attached to HIV infection, J'Mia (and other HIV infected individuals in similar situations) will be unlikely to share her HIV status with sexual partners. This is a problem because it puts others, possibly sero-negative<sup>2</sup> (non-HIV infected) persons at risk.

Another problem that poverty causes amongst Black Americans is unequal access to healthcare. According to Fullilove, Black Americans have “higher rates of morbidity and mortality for conditions such as diabetes, cardiovascular disease, some forms of cancer and HIV/AIDS...health care received by African Americans and Hispanics was of lower quality and more difficult to access than that received by whites” (Fullilove 2006:11). In addition to experiencing worse health, Black Americans have difficulty accessing healthcare. As a result of the difficulty, Black Americans tend to be diagnosed with and start treatment for HIV (and all diseases in general) considerably later than their non-Black counterparts. Late diagnosis means that these individuals are spreading HIV unknowingly, and starting treatment late means that patients are much less likely to survive.

I must point out, however, that structural difficulty is not always the reason why Black people seek medical attention later. I have seen, from personal experience, Black people neglect going to the doctor when they have a problem. My father, for example, hates seeking medical attention because he does not trust the medical establishment, and because of his pride. Masculinity is extremely important to Black males; they do not want to admit that they have a problem. I have also seen Black women neglect medical attention because they are preoccupied with taking care of the family. Black women, in my experience, tend to be the support system

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<sup>2</sup> “Sero-” relates to the word “serum,” a product of blood. As it relates to HIV, “sero-status” refers to HIV status, that is, whether or not HIV is present in the blood. “Sero-negative,” then, means HIV is not present in the blood, and “sero-positive” means HIV is present.

for the family, and put every member of the family before themselves. This leads to my next point, about psychological factors that prevent Black Americans from seeking medical attention.

Black Americans distrust the medical establishment because of experiments like the 40-year Tuskegee study, during which Black males with syphilis were observed, but not treated, even though penicillin was proven to cure the disease. Further, Black Americans tend to have negative outcomes in their experiences with medical professionals. In a study conducted by the Institute of Medicine, researchers found that “doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support...even after patients’ income, education, and personality characteristics were taken into account” (Fullilove 2006:15). Distrust of the medical establishment, negative experiences with clinicians and medical practitioners, and inaccessibility of health care lead Black Americans to be diagnosed later, delay, or neglect treatment altogether.

Another factor driving the HIV/AIDS epidemic in the United States is incarceration. Black men make up about 40% of the incarcerated population in the country (Fullilove 2006:19). This causes a huge problem for Black Americans, because prisons are a source of HIV infection for many Black men. The sex, tattooing, and drug use that occur inside of male prisons leave inmates vulnerable to HIV infection (as well as other blood-borne diseases, such as hepatitis C). According to Fullilove, “The U.S. Department of Justice found that in 2003 the AIDS rate among U.S. prisoners was three times that of the general population” (Fullilove 2006:20). Individuals who are poor and commit crimes, or are intravenous drug users, are more likely to be infected with HIV, and as a result of their impoverished state or status as a drug user, are also more likely to be incarcerated, especially if they are Black.

These HIV infected people enter prison, have sex with or share needles with other inmates, and infect those were negative upon entry. One study done in a southeastern state found that 33 of 5265 male prison inmates (.63%) were infected with HIV during their incarceration (Susan Okie 2007:107). Other studies have shown that the percentage of male inmates who have sex with other inmates range from 2 to 65% and the percentage of inmates who are sexually assaulted range from 0 to 40% (Okie 2007:107). The fact that HIV infected people tend to be overrepresented in prison coupled with the fact that sex, drugs, and tattooing take place in prison, creates an optimal situation for the spread of HIV. What is worse is that condoms are banned or unavailable in 95% of prisons in the United States, and there are no needle exchange programs in any prisons or jails (Fullilove 2006:20). These facts reveal two aspects of the United States society: prisoners are treated as second-class citizens; and the conservative nature of the country does not want to recognize homosexual sex. Prisons are, in a sense, breeding grounds for HIV.

Additionally, as a result of the stigma associated with having been in prison, it is extremely difficult for ex-prisoners to gain [lawful] employment. As a result, recidivism, or repeat offending, is extremely common. This is a problem because if a Black male is not infected the first time he is incarcerated, there is a fairly high chance that he will return to prison, which provides another chance to be infected with HIV.

A third reason behind the spread of HIV in the Black community is intravenous drug use. Sharing needles and other instruments is very common among drug users, who often have limited resources and are forced to share. Sharing needles between drug users also forms a sense of community, which these marginalized individuals seek as a kind of defense against their marginalized status. Sharing needles is a problem because it causes direct contact with blood; injecting infected blood into your own blood stream is the surest way of contracting HIV. Many

IDUs are Black, so when AIDS started being seen in IDUs it spread quickly in the Black community. Injection drug use accounts for over 19% of HIV infections in Black Americans (Fullilove 2006:16). The ban on federal funds towards needle exchange programs contributes to the spread of HIV among IDUs. There is an intersection with prison, as I suggested in the previous paragraph. IDUs have a higher risk of being incarcerated, so even if they are HIV negative upon entry they have a chance of becoming infected in prison. Once they leave prison, they are likely to return to drug use, and will infect their needle-sharing and sex partners.

## **Women**

Since the beginning of the HIV/AIDS epidemic, women have been an after-thought. Even the woman who identified the HIV virus, Francoise Barre-Sinoussi, was not given the credit for this finding (Susser 2009:21). As the epidemic in the United States began in gay men, they were and continue to be the center of attention. Not until around 1990, ten years after the first reported cases, was attention paid to women's risk for HIV infection (Susser 2009:20). When women finally received attention, they were seen as vectors for HIV, capable of spreading it to men and to their children. As a result of this fear of affecting fetuses, women were left out of drug trials during the 1980s. This means that early drugs had different side effects and manifestations in female bodies than they did in male bodies.

Further, early researchers in the United States solely focused on HIV/AIDS in White males, so that "...the models developed with respect to gay middle-class men became the basis for diagnosis of HIV among both men and women...typical symptoms [were] based largely on

North American and European experience...” (Susser 2009:23). This was problematic because it created difficulty in identifying symptoms for women (as well as for racial and ethnic minorities). After protests by women’s groups, however, the Centers for Disease Control and Prevention (CDC) changed its criteria in 1994 (Susser 2009:23). While the diagnosis and treatment of women has increased, there are still social problems that negatively affect women and leave them vulnerable for HIV infection.

HIV infections in women have been increasing in recent years, from what I believe to be a direct result of unequal power relations between the genders. When thinking about HIV/AIDS in women, I think about the lack of control afforded women. Women have less power to negotiate condom use (or sexual activity in general) and fewer opportunities for employment, leaving them dependent on men.

Traditional gender roles are one way in which women are oppressed and offered fewer economic opportunities. In an article about gender and power determining risk for HIV infection, Gina M. Wingood et. al explain, “Often, women are assigned different and unequal positions relative to men. Women are often delegated the responsibility of ‘women’s work’...the nature and organization of women’s work limits their economic potential and confines their career paths” (Gina M. Wingood et.al 2000:542). Because of these unequal opportunities, women become financially dependent on men, who become a source of stability for the women. Generally when a woman is economically dependent on a man, she will do everything in her power to keep him around, even if it means putting herself at risk of HIV infection. Economic dependence on men is not the only result of the lack of opportunities for women.

Another result is that women turn to commercial sex work for money. Wingood et al. write,

“...novices are less likely to use condoms. Prostitutes who are novices may be less likely to adopt HIV preventative practices because they may perceive such practices as threatening their opportunity to support themselves financially” (Wingood et. al 2000:547). According to the authors, commercial sex work is especially dangerous for young women, who feel powerless to demand condoms. This leaves women vulnerable, as they are forced to choose between their health and financial survival. This is also an example of how logic sometimes does not always lead to the “right” decision; I will return to this later in the thesis.

Another way in which women have less power is physically. Women who are in physically abusive relationships, for example, are less likely to attempt to negotiate condom use or deny sex to an abusive partner. In the documentary *The Other City*, J’Mia also speaks about physically abusive males. She says, “If a man beats me, I’m not going to ask him to use a condom. I’m going to do whatever I can to keep from getting beat.” J’Mia candidly speaks about the reality of many women in this country. Unequal power relations leave women vulnerable to HIV infection, and contribute to the rising incidence among women in the United States.

Although Black people, men who have sex with men, and women are more vulnerable to HIV infection, these are not the only members of society who are at risk. HIV does not discriminate, and can affect any and everybody, regardless of race, creed, religion, gender, or socioeconomic status.

### **No Risk is Vulnerability**

One of my interview questions is “Do you see yourself as being at risk for HIV?” In asking this question I wanted to understand how people think about the epidemic. The only individuals who responded “yes” to this questions were my Black and gay informants. I cringe when I write this, because I worry that I am continuing the stereotype. Representative of the answers of all of my informants, one of my White heterosexual female informants said, “I think my only risk is blood transfusions...I’m sorry to say, this is horrible, but I live in an all-w...a very nice area.” This woman started to say that she does not think she is very at risk for infection because she lives in an all-White area, but stopped herself to say “very nice.” These are the types of opinions that leave Americans vulnerable to infection. HIV/AIDS is always seen as somebody else’s problem, and people do not think it can touch them. These people have been extremely misled.

I cannot blame my informants for thinking that they are not at risk, however. First impressions are lasting ones; when AIDS was first reported in the United States, gay people, drug users, and then Black people were most affected. I think that a lot of people hold on to this, and still see those populations as the at-risk ones, not realizing their own vulnerability. The media attention to AIDS in Africa certainly doesn’t help this; Americans turn a blind eye to AIDS in this country and focus on the epidemic in “third world,” or what one of my informants called, “uncivilized” nations.

While I do understand why so many of my informants do not see themselves as being at risk for HIV infection, I do think that they are living under false pretenses. HIV/AIDS exists in



the United States. There are populations that have a higher risk than others, but HIV/AIDS does not discriminate.

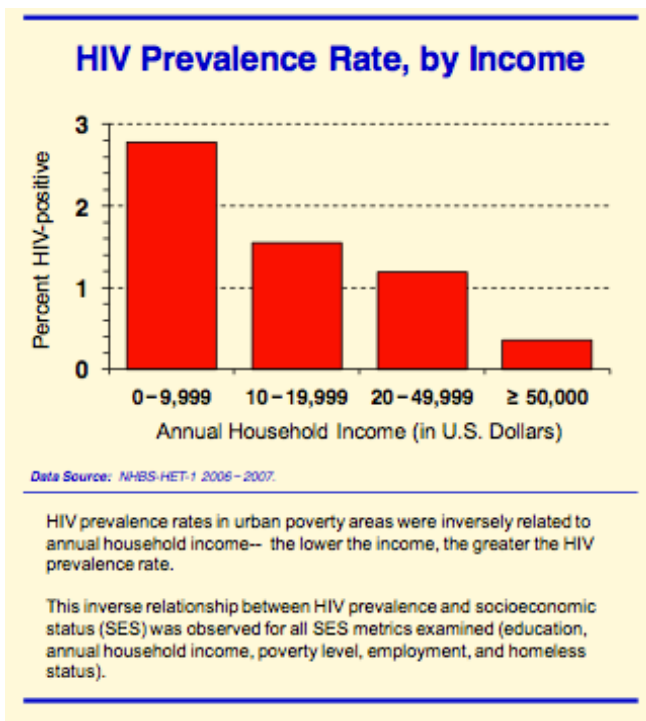
I think that individuals who do not see themselves at risk are actually a vulnerable population, because they are less likely to take precaution to protect against HIV infection. In a study about HIV testing in women, Joseph Inungu et.al report that Black and Hispanic women, because of perceived threat, were more likely than their White counterparts to have been tested for HIV (Inungu et.al 2008:149). This is indication that those who do not see themselves at risk are not going to be proactive in prevention of HIV.

The lack of attention to HIV/AIDS in United States is certainly a risk factor for Americans. HIV/AIDS is almost always linked to developing countries, specifically African nations, which gives American citizens a false sense of security. Because media representations of HIV/AIDS have decreased, many people are under the impression that HIV/AIDS is under control in the United States. Sadly, this is untrue. According to an executive summary from the White House, an American citizen becomes infected with HIV every nine-and-a-half minutes (The White House Office of National AIDS Policy 2010). Of the American population that becomes infected, 24 percent are among people aged 50 or over (The White House Office of National AIDS Policy 2010). HIV/AIDS is a real problem in this country, but American citizens do not see it as such.

## **Poverty**

More than anything, HIV is becoming a virus of poverty. [See figure 3 from a CDC survey]. Higher rates of poverty are associated with higher rates of injection drug use,

prostitution, and incarceration, all factors that contribute to the spread of HIV. This graph shows that individuals living in households that earn between \$0 and \$9,999, essentially at the poverty line, have a substantially higher risk for HIV infection than do their counterparts living in households earning more money. Populations living under these conditions generally tend to be people of color, specifically Black, who are already marginalized in this society. Their poverty status, and possibly their HIV infection, contributes to their further marginalization, which I believe will shape the future of this country.



[Figure 3 From *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?* By Paul Denning, MD, MPH and Elizabeth DiNenno, PhD. 2010. Sponsored by the Centers for Disease Control and Prevention]

In addition to poverty serving as an indicator of risk for HIV, poverty has a direct result on how HIV infected individuals living in poverty experience the virus. I researched a few of the drug regimens that the National Institutes of Health (NIH) recommend for people taking

antiretrovirals for the first time. The NIH recommends one of the following drug cocktails: Atripla (a combination of three antiretrovirals in one pill, which costs \$16,536 per year); Reyataz + Norvir + Truvada (\$27,112.40 per year); Isentress + Truvada (\$22,848.36 per year) (National Institutes of Health 2011). Who can afford these drug regimens? Only those with health insurance or those who are extremely wealthy and can afford to pay out of pocket. Unfortunately, these are not the people who are infected with HIV. Those infected with HIV, as the graph above shows, are impoverished, and will certainly experience high mortality.

Implicit in this discussion is the political economy of health in the United States; healthcare is becoming a luxury rather than a human right. This, I believe, will lead to a permanent underclass of citizens in this country. Impoverished communities will continue to suffer ill health, will not have adequate access to treatment, and will experience higher mortality, while the upper classes flourish.

I have laid out the factors that initially created vulnerability for HIV infection among the American population. The rest of this thesis will focus on the other factors that have continued the epidemic and exacerbated the situation.

## Stereotypes

Stereotypes about people infected with HIV or AIDS are common, and always negative. The categories of stereotypes that I have found to exist include: Africans; homosexual men; poor people; Black people; drug abusers; promiscuous people, especially women; and overall careless people.

The persistence of these negative opinions about people with HIV/AIDS leads people to believe their own invincibility and see HIV as an “other” disease. If someone who does not belong to one of these categories only hears these stereotypes about people with HIV/AIDS, he will likely believe that he is not at risk. When I asked my informants about stereotypes they have heard about people with HIV, I got many similar responses. This chapter will serve to explain these stereotypes and the negative impact they have on prevention of HIV.

One of my Black male informants said:

I have heard stereotypes, I've heard like people who have HIV are usually stereotyped as being intravenous drug abusers, addicts. Uh, sexually promiscuous, sleep around with multiple people, not asking, not knowing, or just sometimes not caring if they have HIV, and just spreading it because they're like I wanna get revenge on these people, I wanna get revenge on who gave it to me.

This informant hinted at the drug abuser, the promiscuous, and the careless person stereotypes.

Another informant, a White male, said, “I definitely think the stereotype of HIV infection being associated with homosexuality still exists...I have a straight girl friend and when I told her she could get HIV from having unprotected sex she was surprised.” This informant happens to be gay as well, and he and I discussed how we, as very at risk people, sometimes feel the burden of having to educate people and be advocates against HIV. We both worry that we perpetuate the stereotypes; a Black woman and a gay male standing on soap boxes speaking out against HIV. This worry is something that I have had to come to terms with while writing my thesis. I have realized that I cannot concern myself with what people will think in reaction to my thesis. The HIV/AIDS epidemic in the United States is truly a crisis situation, and we need to speak out.

One of my White female informants said, “I think the stereotype of a junkie...[someone living in] poverty, some lazy bum who just does drugs and doesn’t take care of their kids...gay men stereotype is there.” Again, the stereotype of HIV/AIDS being a gay disease is present, as is the stereotype of the drug abuser being infected.

The most disturbing stereotype I heard was in the form of a question during an anthropology course entitled Global AIDS Epidemic. In this class, we have learned about populations at risk, how structural violence and systemic injustice contribute to the spread, and how social factors are crucial in analyzing the epidemic. One day we had a lecture about AIDS in African Americans, and there was a question from one of the students in the class. This young woman raised her hand and said “are Black people genetically susceptible to HIV infection?” We had just read an article about the social factors, such as poverty, inadequate housing, and injection drug use, that contribute to the epidemic in Black Americans, and this girl *still* did not

get it. My initial reaction to this question was anger; I was shaking in my seat, wondering how this young woman could honestly ask such a question. As a University of Michigan student taking a course about the HIV/AIDS epidemic, how could she not understand how structural violence plays a role? How could she genuinely believe that Black people are genetically susceptible? If this young woman can believe this, with all of the education she has been given, no wonder other, less-educated Americans can believe these stereotypes and be so misled about the epidemic. This student also serves as evidence that knowledge is not always the best tool for prevention. The stereotypes and misinformation about the epidemic is rooted so deeply in the minds of countless Americans that even education sometimes does not help.

Lastly I want to discuss what a White male informant said about stereotypes he has heard: “Lots of stereotypes about Africans...a lot of prevention strategies tend to represent the continent as a diseased space.” This comment was interesting to me because my informant spoke about the representations of Africa as the “dark continent,” which I think are detrimental to prevention efforts in the United States. All of the emphasis on AIDS in Africa enables people in other parts of the world, such as in the United States, to falsely believe that HIV/AIDS will not affect them.

My informant continued saying, “Also, the gay stereotype, one I’ve experienced...because you are gay you have HIV.” The fact that he has experienced the gay male stereotype himself is problematic. Thirty years into the epidemic, the stereotype still exists. This, in my mind, reveals the power of the media. In the beginning of the epidemic, the media portrayed AIDS as the “gay disease,” but once other populations started being affected the media representations decreased. People clearly still have the image of the gay male infected with HIV/AIDS, even though the epidemic affects other sectors of the population.

This statement also made me think about my roommate's friends who do not think that they can get HIV because they are not gay. I struggle with how to combat this stereotype without starting or perpetuating another. I think that because HIV/AIDS is such a scary topic, and because people do not really understand it, everyone wants to view it as the "other," something that will not touch them. If, for example, Black women start speaking out, I worry that non-Black women will look at HIV/AIDS as a Black woman disease and still not believe their own vulnerability. Individuals need to start seeing HIV/AIDS as an "us" virus, something that can infect any and everyone.

This short segment serves to segue into the stigma section that will follow. The negative stereotypes about people with HIV/AIDS contribute to the stigma. Because people attach such negative attributes to HIV/AIDS, the stigma exists.

## Stigma

Stigma is a word that is used often and that essentially refers to socially inferior attributes associated with “norm infractions” (Page 1984:4). In discussions about HIV, this definition refers to the feeling that somebody did something “abnormal” to become infected with HIV. In his discussion about stigma, Robert Page quotes Erving Goffman, writing, “an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us” (Page 1984:5;Goffman 1986:14-15). I think this definition is especially salient as it relates to HIV infection, because once people find out that an individual is HIV positive, that becomes the defining feature. For example, when Magic Johnson announced his HIV infection, many of his former teammates, who used to admire him, shunned him, ignoring every other trait that once made them friends (Nelson George 2012). In addition to being associated with norm infraction, stigma comes in different forms.

Goffman writes, “First there are abominations of the body...Next there are the blemishes of individual character perceived as weak will, domineering, or unnatural passions...Finally there are the tribal stigma that can be transmitted through lineages...” (Page 1984:4;Goffman 1986:14). For the purpose of this thesis, I will focus on the type of stigma associated with “blemishes of individual character,” or what Robert Page calls “conduct stigma.” The stigma around HIV certainly is the “conduct” type, because people think you must have done something wrong if you are HIV positive.

In an article about the factors responsible for stigmatization of HIV/AIDS, authors Gernot Von Collani et.al explain that stigmatization stems from homophobia and fear of



contagion (Von Collani et. al 2010:1748). I think that homophobia is certainly one factor, but I reject that the fear of contagion is a factor anymore. None of my informants mentioned a fear of contracting HIV/AIDS from being in contact with an infected person. I must point out, however, that the study was conducted in Germany, which may explain this discrepancy. I believe that In the United States most people think of HIV as a sexually transmitted disease, which is part of why it is such a taboo subject. More than anything, I see the stereotypes present, like the ones I discussed in the previous section, as the major factors behind stigmatization of HIV/AIDS. If all you hear is the stereotypes about HIV/AIDS, of course you are going to look at infected individuals negatively and/or judgmentally.

Several of my informants spoke about the role of stigma in the HIV epidemic. One of my informants, a White female, said: “When thinking about HIV it’s never just thinking about the virus, it’s ‘oh, what did they do to get it?’” This informant evidences the “conduct” stigma that Page and Goffman describe, demonstrating how HIV infection is associated with a certain behavior that is worthy of blame.

Another one of my informants, a Black male, spoke about the stigma as well. When I asked him if he thinks that having a Black celebrity stand out in the battle against HIV would help he responded:

I think it would help, but at the same time I think it would be kind of hard, cause we have like a lot of fears. I feel like it’s easier for White men to step out and say “yeah I have this disease, I can live with it,” but for us it’s like we have that stigma, like “somebody gonna see me, I gotta keep my image up, you know if I go to the clinic I don’t want my friends to see me, my mama might see me.” So, it’s that stigma and that

fear attached with it that's kind of hard to overcome for the minority population.

In response, I asked this young man why he thinks the stigma exists, to which he explained:

I feel like sometimes conservatism. Like a lot of Catholic religions, probably like, Latinos, are real conservative, and they don't want to denounce their religious affiliations or anything like that. So they wanna keep their image up as being holy...And if you're [a woman] like sleeping around you're seen as a whore, or la maninche, which is like another depiction of a goddess, an Aztec goddess who slept around with Spaniards, so you're seen as a traitor to your race, you're seen as a traitor to your man, the Latino man, so they don't want to be seen as that.

My informant touched on several interesting points in this segment. The first thing I want to point out is his acknowledgement of the role of religion in the HIV epidemic. Secondly, he spoke about the racial element of the epidemic. I think that his comments about race fit into my discussion about homophobia and the double stigma (which will come later in this thesis) but in this case, individuals do not want the double stigma of being Black (or Latino) and HIV infected. I also want to emphasize his point about the woman being promiscuous, which leads to her HIV infection. This goes along with the stereotype of the promiscuous woman putting herself at risk for infection, which causes the blame factor so entrenched in HIV infection.

As several informants have revealed, individuals living with HIV are often seen as having done something wrong. An evangelical Baptist minister, Jerry Falwell, called AIDS “God’s judgment on promiscuity,” and former senator Jesse Helms once said that “AIDS funding should be reduced because homosexuals contract the disease through their deliberate, disgusting, revolting conduct” (Helen Epstein 2007:186). While these men made the comments during the 1990s, they demonstrate the stigma attached to HIV, and how HIV infected individuals are viewed in American society. Americans may not be as open about their disdain towards HIV infected people, but the stigma still exists.

I made several announcements to student organizations and groups (the majority of which were composed of mostly Black students) I put up flyers about my thesis, and only managed to interview 13 people, three of whom people were Black. I cannot assume why more Black students did not respond to me, because I certainly do not know the reasons behind anybody’s behavior. That said, however, one of my Black male informants told me, “people probably don’t want to be interviewed because they either think you have HIV or think that people will think they have HIV if they talk about it with you.” At first this statement was shocking, but I do believe there is merit to what he said. HIV is an extremely taboo topic in the United States, because of its association with sex, homosexuality, and drug use.

In addition to my own experience writing about HIV, there are current events that demonstrate that the stigma still exists. In December of 2011 a middle school student was denied admission into the Milton Hershey School because he is HIV-positive. In an interview on Anderson Cooper’s *Keeping Them Honest*, a representative from the school said that the thirteen year-old-boy would pose a direct threat to the students, and had no qualms about publicly stating that his HIV positive sero-status was that he was not admitted (Anderson Cooper 2011). This

clearly is an act of discrimination, but the school had no problem with this. This blatant example of discrimination reveals how current administrations are perpetuating the stigmatization of HIV. The school administration did not even want the teenager to be around other children, even though HIV is not a communicable disease.

I think that the stigma around HIV exists because of the fact that HIV was first known in the United States among homosexual men, and then spread to other marginalized populations, such as heroine addicts and prostitutes. Every single person I interviewed alluded to the fact that HIV is associated with gay people or “bad” behavior, which suggests that this is a widely held belief. As a result of the stigma, individuals do not want to get tested, or even have people see them entering an HIV/AIDS clinic. Lack of knowledge about HIV status is a major factor in the spread.

Besides the association with marginalized populations, the criminalization of HIV has added to the stigma. 36 states have HIV disclosure laws, meaning that it is illegal for an HIV infected individual to engage in sexual activity without disclosing his HIV status. In 95% of these cases, or in 24 states, transmission of HIV is not a condition for imprisonment, and in 83%, or in 20 states, no *risk* of transmission is even necessary for imprisonment (Hoppe March 15, 2012). In Missouri, for example, it is considered a felony for an HIV infected individual to engage in sexual activity, the maximum jail sentence is life in prison, and the transmission of HIV is not a requirement for imprisonment (Hoppe March 15, 2012). The majority of these laws were passed during the 1980s, when there was still a great fear of HIV infection through casual contact. As these are state laws, the statutes vary; individuals can be penalized for “risky sex,”

nondisclosure, and transmission. Some states even prosecute people for attempted murder or aggravated assault (Hoppe March 15, 2012). In the state of Michigan:

A person who knows that he or she is HIV infected, and who engages in sexual penetration with another person without having first informed the other person that he or she is HIV infected is guilty of a felony...sexual penetration means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required (Hoppe March 15, 2012).

This law means that transmission of HIV is not required for an individual to be prosecuted of a felony. It also means that insertion of a non-body part, such as a sex toy, can be considered a felony as well. In the latter case, there is no risk of transmission, but the HIV infected individual can be imprisoned.

In 2010, a Macomb County Michigan resident was convicted of bio-terrorism after reportedly biting his neighbor during a physical fight. The man, Daniel Allen, and his neighbor were in a physical altercation after the neighbor, his father, and his wife, were verbally assaulting the man in an anti-gay tirade. Allen later admitted that he is HIV positive, and was charged with "possession or use of a harmful device" (Todd Heywood 2010). The judge convicted Allen, even though HIV cannot be transferred through saliva.

In another similar case, in 2008, an HIV infected homeless man was sentenced to 35 years in prison after spitting on a police officer. This man was convicted of “harassing a public servant with a deadly weapon,” ie his saliva (Gretel Kovach, 2008). Again we see that the biology and facts of the HIV virus are overlooked in these two cases, and the stigma associated with the virus overruled. The judges who prosecuted these HIV infected individuals are more concerned with getting the “undesirables,” meaning homeless, HIV infected, and/or homosexual populations, out of society than about the reality of the HIV virus.

These two cases are extremely problematic, because they imply that people living with HIV, even if they do not pose a threat to others, are seen as criminals worthy of imprisonment, solely because of their serostatus – HIV status. This labeling of HIV infected individuals as criminals adds to the stigma of the virus, and makes prevention of the spread increasingly difficult.

The most harmful result of criminalizing HIV is that it discourages individuals from getting testing and knowing their HIV status. If you know that being HIV positive and having sex with another person is a crime, would you want to know your status? Not knowing your HIV status negates the obligation of disclosure, as well as the risk of being prosecuted for sexual activity. When people do not know their HIV status, they can more easily spread the virus, enabling the epidemic to continue ravaging populations.

In addition to penalizing American citizens with HIV, the United States did not allow visitors from other nations who were infected with HIV into the country until 2010. The Public Health Service under Ronald Reagan banned travel and immigration to the US by individuals infected with HIV, and Congress added the ban to US immigration laws (Franke-Ruta 2009). Not until Barack Obama’s presidency was this ban overturned, with the renewal of the Ryan

White HIV/AIDS Treatment Extension Act of 2009 (Franke-Ruta 2009). The addition of this ban into immigration law reveals how stigmatized this virus is, and the message this law sends is clear: people living with HIV are an unwanted population. This ban certainly had negative impacts on the lives of people living with HIV during the 1990s. At the same time, however, President Obama's overturning of this ban signifies the beginning of a change. The overturn is a message to American people that HIV infected people should not be feared, and I hope that it can decrease some of the stigma associated with HIV infection.

There are several effects of stigma on individuals with HIV. The first result of experienced stigma is psychological stress, something that weakens the immune system, making the virus progress faster in the individual's body. Mental health reactions to experienced or perceived stigma, that is, stigma that individuals believe others hold of them, include panic, anxiety, and depression. According to Mark L. Hatzenbuehler, this psychopathology "interferes with HIV disease management, including medication adherence..." (Hatzenbuehler et.al 2011:231). This is a problem because HIV infected individuals who experience or perceive stigma are less likely to follow their treatment, enabling the virus to progress in their bodies and to spread more easily.

In a study about barriers to HIV treatment among women in the Deep South, authors Linda Moneyham et al. explain that stigma is a factor in deciding not to seek treatment. The authors cite several women living with HIV. One quote in particular, about the location of HIV treatment centers, stuck with me. One of the study participants said:

...It's not so much you are afraid or anything, it's the repercussions (of being seen)...when you walk back out this door, you gon' run into somebody that know you...or somebody gon' pass by or

something...When they (people living with HIV) find out where it (HIV care site) is, they don't want to be seen...They won't come...(Moneyham et al. 2010:471).

This woman reveals that the stigma of the HIV treatment center itself discourages people from seeking treatment. According to her, the people living with HIV in this area do not want to be seen going into a treatment center for fear of being discriminated against. This certainly is a barrier to prevention, because if you do not want to be seen even entering a center, you will be less likely to access treatment, thus enabling the spread of the virus. This statement also reveals that the availability of resources is not always a factor in the decision to seek treatment, as I mentioned in a previous section.

Additionally, experienced or perceived stigma leads to more risky behavior, meaning unprotected insertive or receptive intercourse, amongst HIV infected individuals (Hatzenbuehler et al. 2011:231). This riskier behavior, matched with the decreased likelihood of medical adherence, poses a barrier to prevention of the spread of HIV. While the direct link between perceived stigma and risky behavior is still unknown, the fact that the link exists is worthy of attention. I hypothesize that the perceived stigma decreases self-esteem, thus creating the desire for affection, coming from unprotected intercourse.



## Homophobia

Homophobia is another major obstacle to the prevention of the HIV epidemic in the United States, particularly among gay Black American men. There are several origins of this homophobia, with the most influential being concepts of masculinity, racial survival consciousness among Black Americans, and religion.

In his article about hyper-masculinity and homophobia, E.G. Ward explains that concepts of masculinity in United States tend to be over-exaggerated, and include aspects such as the assertion of power, both physically and sexually (Ward 2005:496). Inherent in this discourse are heterosexism and homophobia, even the demonization of the homosexual (Ward 2005:496). This hyper-masculinity is especially salient within the Black community, because of historical sexual representations of the Black male as bestial and sexually uncontrollable. These representations leave Black masculinity in a state of “crisis” (Ward 2005:497). In order to compensate for this masculinity in crisis and create their own narrative, Black males tend to be hyper-masculine, like the rappers seen on television denigrating women, and tend to use homophobia as their opposite, to define what a man is not (Ward 2005:497). This is problematic because Black young men, when coming into their sexuality, see their “role models” disrespecting women and being hypersexual, and emulate this behavior. This type of hyper-masculinity often leads to more sexual partners, which leaves all of the parties involved at a higher risk for HIV infection, especially Black women.

While I do understand the creation of counter narratives in response to the representations of Black male sexuality, I find the expression of the counter narrative to be paradoxical. If Black people, males specifically, have a problem with sexually deviant representations, why would the

response be hyper-masculinity? I do not yet have an answer for this question, but I understand that the creation of these counter narratives has had deleterious effects on this population.

In addition to the hyper-masculinity among some Black males, a consciousness of racial survival is also a source of homophobia within the Black community. When I read Ward's article, I immediately thought about a conversation I had with my younger brother. I asked him why he thinks that Black people are so homophobic and why gay Black males do not want to admit their homosexuality, to which he responded, "Black people have enough to worry about. We're already discriminated against for being Black, why would we want another stigma on top of that?" My brother, a heterosexual Black male, alluded to the fact that Black Americans, with the highest numbers of poverty, mortality, unequal opportunities, and systematic imprisonment, have enough trouble trying to survive in this country, which encourages homosexuals to hide their sexual preference in order to prevent an extra layer of discrimination.

One of my Black male informants touched on this idea of hiding homosexuality as well. I asked him if he thinks that homophobia is a problem, to which he said, "Yeah...our intolerance to it [homosexuality]. It's just a gay bashing, people getting killed, transgender people getting killed, they don't want to be marked out as the one to be killed next." My informant reveals one reason why homosexual men would try to hide their sexual preference, to prevent discrimination, or even physical consequences.

Expanding on this notion of racial survival, Ward explains:

...Black homophobia in North America is rooted in the moralisms and imperialism – of both Western and traditional African religious beliefs.

These homophobic religious moralisms have dovetailed with the urgency

of a racial consciousness of survival and preservation among blacks, that sought to construct black masculinity as the struggle against white domination...whiteness and homosexuality are both understood to connote weakness and femininity..." (Ward 2005:496).

This fragment fits with the hyper-masculinity of the Black male that was discussed earlier. In an attempt to "survive" in this country and have a sense of self, Black men created an image that is *not* homosexual and that is *not* white. To my understanding, the need to survive is linked to being heterosexual because it leads to reproduction. Homosexuality does not produce offspring, which would not allow "survival," or a continuation of the Black race in this country. I think that this issue is particularly salient today, when the number of Black men being incarcerated is rising. With more Black men behind bars, there is a void in the Black community, which threatens racial survival. Homosexuality only adds to this void. I have often heard the saying "There are so few eligible Black men. They're either in jail or they're gay." With phrases like this being thrown around and the Black race seemingly threatened, homosexuality is seen as a problem.

The irony in this consciousness of racial survival is that in rejecting homosexuality, Black Americans are contributing to the HIV/AIDS epidemic in the community, thus threatening their own survival.

In an article about differences in disclosure of sexual preference, J. David Kennamer et. al. also touch on the consciousness of racial survival as an origin of homophobia amongst the Black community. The authors write:

Numerous writers have pointed out that in reaction to racism and discrimination, middle-class African Americans in particular have felt the need to prove that they are "just as nice as those white folks" (Cohen, 1996, p. 376), thus promoting a social conservatism that is perhaps more repressive than that of the white middle class. Cornwell (1994) noted the "extreme conservatism that prevails in the black community-a conservatism that most white people are totally unaware of" (p. 468). Homosexuality, as well as other "deviant" sexual behavior, becomes "an embarrassment to the collective consciousness and cultural capital of the black community" (Kenamer et al. 2000:Cohen, 1996, p. 378).

According to the authors, middle-class Black Americans feel this pang of racial survival particularly strongly, and in an attempt to negate the stereotypes about Black people, become extra socially conservative to demonstrate that Black people are not sexually deviant or uncontrollable.

I think that this type of opinion has detrimental consequences on the Black community in this country, as it creates divisions and builds an "us versus them" mentality amongst Black Americans. I have witnessed how middle-class Black Americans, in an attempt to negate the negative stereotypes, often segregate themselves, physically and mentally, from Blacks of lower socioeconomic standing. If Black Americans cannot stand in solidarity with one another, the fight against HIV/AIDS, as well as all other obstacles that Black people face, will continue to be a losing battle.

Hyper-masculinity and the need for racial survival are specific to Black Americans, but there is one other source of homophobia that is not specific to this population: religion.

Most commonly, individuals who are homophobic cite the Christian religion as the source of their anti-gay sentiments. The documentary *For the Bible Tells Me So*, directed by Daniel G. Karslake, discusses the sources of homophobia that are cited as having Biblical origins. The overarching source was Genesis chapter 19, in which the cities of Sodom and Gomorrah are destroyed because sodomy took place. Echoing these religious sentiments, Gregory B. Lewis writes:

Beliefs about homosexuality and support for gay rights vary substantially by religion (with Jews the most accepting and born-again Protestants the most disapproving) and by intensity of religious feeling (disapproval is highest among those who attend religious services frequently, who pray frequently, and who say that religion is very important in their lives...)”  
(2003:66).

Because of the relationship between homosexuality and HIV, that is, men who have sex with men have a higher risk of contracting HIV, this homophobia serves as a major obstacle in the fight against the HIV/AIDS epidemic in the United States. The stigma associated with being homosexual discourages individuals from admitting their sexual preference and from listening to public health messages targeted towards the homosexual community.

Masking homophobic ideas under the veil of religion is especially true among Black Americans, who in general tend to be more religious than do their white counterparts (Pitt 2010:56). One of my informants, a Black female, spoke on this extensively:

The churches...people get the most of their information, in terms of the black church...people take what the preacher or the minister says at a very high regard...people take their pastors at a higher regard than they take their physicians. If you don't have pastors talking about it [HIV], or even making it aware that it is a problem, but you do have the doctor saying it's a problem, who do you think they're going to believe? There is a long legacy of the black church facilitating dialogue about leadership, consequences of race, the need for racial uplifting, economic opportunity, job growth, employment...the Church is the pinnacle of influence in the Black community...the Black church has much more influence than say, a public service announcement can ever have. If you don't have the Black church talking about it...I think it becomes an American tragedy.

I did not bring up the church in this interview, but rather my informant cited the church when I asked her why people are still being infected with HIV. The Black church is failing to discuss the HIV epidemic because of its association with homosexuality, and sex in general, taboo topics.

As the Church has had such an influential role in the lives of Black Americans, the Church's failure to speak out against HIV/AIDS, as well as its condemnation of homosexuality, is detrimental to this population. Lewis highlights this fact, writing:

African Americans attracted to their same sex tend to face more disapproval from their families and straight friends than do similar whites. Given the link between perceptions of homophobia in the black community and both lower self-esteem and riskier sexual behaviors among black men who have sex with men, this disapproval places even greater obstacles to self-acceptance and safe sexual behaviors in the paths of black youths...(2003:75).

The Church's condoning of homophobia makes prevention against HIV difficult for several reasons. The first is that, like Lewis wrote, openly homosexual Black Americans tend to have lower self-esteem and engage in riskier behavior, which renders them more vulnerable to HIV infection. The homophobia that is so prominent in the Black American community also makes it difficult for individuals to be open about their sexual preferences. This leads to what is commonly known as "being on the down low," or being a closeted homosexual or bisexual individual.

Kennamer et. al discuss this subject, writing, "Several studies have indicated that more closeted men (e.g., heterosexual or bisexual-identified men whose sex partners are mostly men and married men who are homosexually active) engage in risky sexual behavior more frequently than men who are more open and accepting of their sexual orientation" (2000). Men who are "on the down low" put themselves at risk by engaging in unsafe behavior, and the male sex partners of these homosexual men leave their women counterparts vulnerable for infection as well.

This risk-taking behavior amongst homosexual men who perceive stigma is not specific to the Black homosexual community, however. In an article about the impact of attitudes about homosexuality on HIV prevention, Theo G. M. Sandfort explains, "...social participation with other gay men was a predictive of safe-sex behavior among men with higher positive attitudes toward their own gay identity" (Sandfort 1995:37). While this article is fairly outdated, I believe that the fact is still relevant. When homosexual men are more open about their sexuality and more engaged in their community, they are more likely to adhere to safe sex practices. Sandfort expands on this point explaining, "Having negative attitudes toward homosexuality while actually engaging in same-gender sexual contacts might result in psychological conflict...[which] might impede one's attempt to avoid unsafe sex" (Sandfort 1995:41). Being exposed to homophobia could lead to internalizing these feelings, which causes an internal conflict, leaving the individual more likely to engage in risky sexual behavior. This risk-taking leaves the man himself, as well as his partners, vulnerable to HIV infection.

One of my Black male informants spoke about the "down low" factor contributing to the HIV epidemic in the United States. When I asked him if he feels that he is at risk for HIV he responded:

I do see myself being at risk, and being a Black male, especially with a lot of African American MSM, men having sex with men, going around. I'm not having sex with men but still...And also with like, Black women getting HIV/AIDS, because a lot of men are being on the down-low. And you don't really know if your girl might have it, because she slept with a guy [who had sex with a man].



This informant reveals how Black men “on the down low,” who sleep with both men and women, pose a risk for Black women as well as other Black men who sleep with these women. I think that if homosexual Black men felt more comfortable sharing their sexual preference, some of the problems affecting Black Americans in the battle against HIV would cease to exist.

Black homosexual youth are at an especially high risk for HIV infection because of the homophobia with the community. In an article about youth risk factors for HIV infection, Winifred Montgomery writes:

Social and cultural biases that promote homophobia hinder young gays from seeking information about healthy sexual relationships.

An unfortunate result is that a great many of these young men leave home.

Prostitution becomes a means to support themselves, and other unhealthy practices such as injecting drugs and unprotected casual sexual relationships further increase their risk for infection (Montgomery 2004:369-70).

A major problem that Montgomery does not mention is the over-incarceration of LGBTQ youth of color. As a result of their families’ denial of their lifestyle, these youth become homeless and/or turn to prostitution, which leads to their incarceration and leaves them vulnerable to HIV infection. I had a conversation with a Black gay male who explained this process to me, and how the stereotypes negatively affect LGBTQ youth of color while in prison. He told me that quite often, inmates have the stereotype of the “sexually promiscuous” Black

male, and prey on gay Black youth. He also mentioned that homosexual youth of color are raped at higher rates than their heterosexual counterparts.

Additionally, the homophobia that is so present among the Black American population in particular has led to a silence about HIV/AIDS on the part of Black leaders, because homosexual and bisexual Black Americans are not organizing and lobbying for social change. Kennamer et al. write:

In the classic terms of modern pressure-group politics, these African American politicians and leaders have not had organized constituencies expressing outrage and demanding action about the continued rampage of HIV/AIDS through their ranks. If, as Peterson (1991) has pointed out, there is no "distinct gay culture in the black community" (p. 150), and African American gays avoid gay organizations that have pressed the fight against HIV/AIDS because they perceive them to be exclusionary and racist, then these men and women have truly been absent in the fight against AIDS (2000).

Whereas in the beginning of the HIV/AIDS epidemic, White homosexual men were rallying for their rights, organizing, and protesting, the Black homosexual community has failed to do so. If only homophobia were not so engrained in the mentality of many Black Americans, homosexual Black Americans would be able to unite and fight more strongly against the HIV/AIDS epidemic.

With that said, however, I must mention that there are non-profit and grassroots organizations that target the Black homosexual community, specifically men who have sex with men. One such organization is The Black Gay Men's Network, a product of the Black AIDS

Institute's Gay Men's Retreat. The Network "provides skills-building in leadership development, financial wealth, physical and mental health, and spiritual wellness...[as well as] professional, social and education resources to men at various stages of life who are seeking a healthy community, peers and role models..." (Black AIDS 2012). The mission of this organization is to provide Black gay males with the support and services that they may lack in their lives. The Black Gay Men's Network allows these males an opportunity to build community and organize with men like themselves, and provides an outlet for these men that can be crucial in developing skills to avoid risky behavior. While this organization is only helpful for those self-identified Black males, thus still leaving out closeted gay males, I do think that a program like this is essential to the prevention of HIV/AIDS.

One weapon against the HIV/AIDS epidemic in this country is the end of homophobia.

## Prevention Programs

“Don’t interrupt my breakfast.”

This quote sticks out in my mind when I think about HIV prevention efforts. For about a month I volunteered with an HIV/AIDS non-profit organization at an outreach program, distributing condoms at a breakfast service in a church. The quote above was a response I received when I asked an older man if he wanted condoms or lubricant, and I really cannot blame him. Would you want a basket of condoms in your face at 7:45 in the morning while you were eating breakfast? I wouldn’t.

Every Thursday the outreach coordinator goes to the church in Ann Arbor during its free breakfast service. The coordinator conducts rapid testing in his van, while volunteers walk around to each table to pass out condoms. Before and after passing out the condoms, the volunteers stand in the front of the auditorium style room, sitting on stage with baskets of condoms and lubricant, and informational pamphlets about sexually transmitted infections. One morning I asked another volunteer if she thinks people know who we are. She immediately responded, “not at all.” There are no signs that indicate who the volunteers are or why they are passing out condoms.

When we passed out the condoms and lubricant, we did not explain why we were doing it, nor did we explain the importance of safe sex. I think that this is a major flaw in the outreach program, and a contributor to the epidemic. While the motives behind programs like this are pure, and there is some logic behind them, they are not effective in educating individuals about safe sex behaviors or about the risk of HIV.

The same volunteer who told me that nobody knows who we are also told me that handing out condoms at the breakfast service is a good idea because of the homeless population that attends. According to her, HIV among homeless individuals is fairly high, so with this knowledge I do understand the logic behind handing out condoms at the breakfast service. I do, however, feel that this is a half-hearted effort. These programs do not provide education, and are very individualistic in nature, assuming that everyone has the agency to make “rational” choices if given the proper equipment. Further, programs like this that focus on individual behavior neglect the social contextual factors of behavior, such as cultural norms and power relations, among others. It is important to keep in mind that individuals act within social contexts, and that their behavior is very much influenced by relationships and community standards.

In a book about individual and community action as it relates to AIDS, authors Tim Rhodes and Richard Hartnoll write about this problem and about the importance of community change to prevent HIV/AIDS. Rhodes writes,

Community action interventions...aim to encourage a system of peer support and participation...interventions targeting individual behavior changes alone are limited because they do not necessarily encourage the social conditions in which individuals can actually exercise “choice.” The aim of community change interventions are thus to bring about changes in the community norms and practices which impede individual attempts at risk reduction, and reinforcements in the community norms and practices which endorse safer behavior (Rhodes 1996:6).

I agree with Rhodes’ assertion that community-level interventions are the best way to prevent HIV, for two reasons. The first is that I believe that individual behavior is

most impacted by social contexts. We interact with each other according to what we think is appropriate social etiquette, thus our behavior is shaped by the community in which we exist. I have thought a great deal about HIV/AIDS in heterosexual Black females, and I think that the social context in which we exist is the biggest determinant of our vulnerability to HIV infection. When I walk around campus and realize that most of the Black students are females, or when I hear my Black male friends talk about their negative experiences with the police, I begin to see how the social context affects Black women in relation to HIV infection.

Black males in the United States are incarcerated at alarmingly high rates. In a book about the war on drugs' impact on the Black American community, Michelle Alexander writes, "In some states, black men have been admitted to prison on drug charges at rates twenty to fifty times greater than those of white men...in major cities wracked by the drug war, as many as 80% of young African American men now have criminal records..." (Alexander 2010:7). The high rates of incarceration of Black males create a void for heterosexual Black females, and leave us vulnerable to HIV infection for several reasons. The first reason is that many males get infected with HIV in prison (Centers for Disease Control and Prevention 2006). When these males return home, they infect their girlfriends or wives. The second reason that incarceration of Black males leaves Black females vulnerable is that Black women realize that their options for mates are limited, and may give up their power in a relationship, specifically when it comes to condom use during sex, and become infected. The third and last reason that I see as a problem is the fact that there are more free (not incarcerated) heterosexual Black women than there are men in the United States, which means that Black men have more choices of mates and can have multiple

partners. The multiple-partnership of Black men leaves heterosexual Black women extremely vulnerable to HIV infection.

I realize that these arguments assume racial segregation when choosing mates, and authors Sullivan and Wolitski affirm my assumptions. The authors write, “90% of sexual partnerships in the United States are between persons of concordant race” (2008:229).

My analysis of social context among Black women in the United States has led me to believe that community-level interventions are the most important in preventing HIV infection. I think that this type of intervention would be most successful in changing the set of cultural norms within a community, which would allow for behavior change amongst the entire population. If, for example, a public health intervention worked with an entire community, educating the people about risky behavior, the danger associated with that behavior, and effective ways to reduce this danger, using culturally relative, practical techniques, individuals would be more inclined to change.

The second reason I agree with Rhodes is that I feel that individual interventions can serve to place blame on the people infected. If a program is based on the assertion that you need to change your behavior to prevent HIV infection, I think that the implication of HIV infection is that it is *your* fault that you were infected because *you* did not take the necessary precautions. This type of thinking can have negative effects on the treatment of HIV positive people, and adds to the stigma that these individuals face.

In November, a few Black and Latino sororities, fraternities, and organizations at the University of Michigan held “AIDS in Black and Brown” week, during which there were conversations and other events centered around HIV/AIDS and prevention. I attended one of

these discussions, doing participant observation of the event. Two comments stood out to me that relate to the individual-level interventions causing blame. A Hispanic male said, “We need to teach them [children] to be better people. We shouldn’t focus on sex education, but teach them how to have non-sexual relationships.” Later in the dialogue, a Black male said, “I think that people with HIV did something wrong to deserve it.”

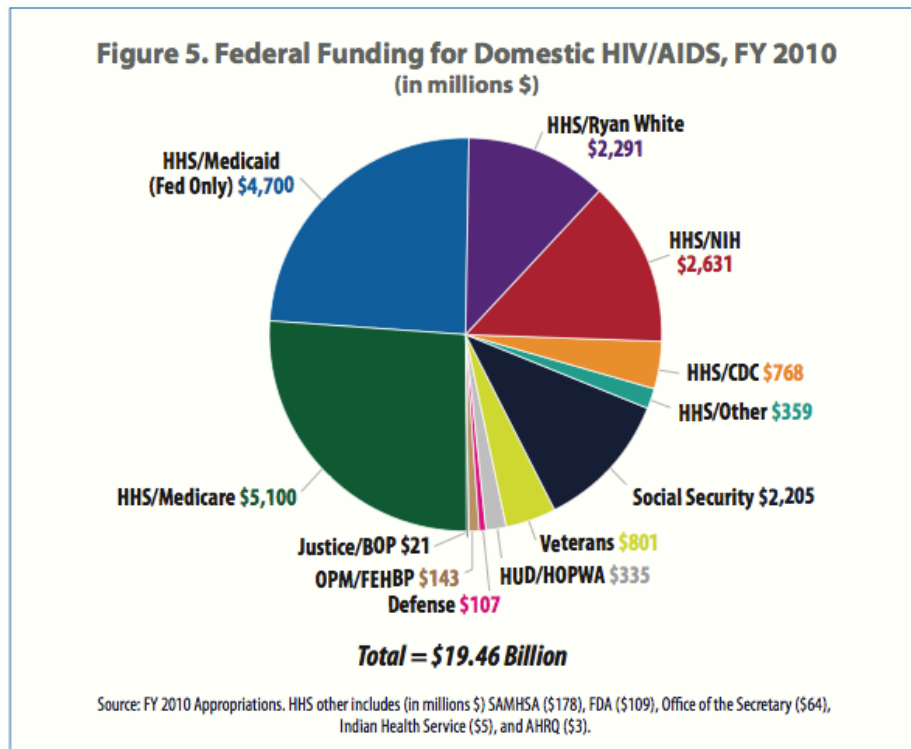
These comments were striking because they so clearly reveal the stereotype that people infected with HIV are inherently “bad” people because of their choices. The comment about teaching children to be better people reflects the conservative, religious undertone of this country; sexual education programs in many schools across the United States are faith-based and rely on abstinence as prevention. I also think that these statements are obvious examples of why it is so difficult for members of minority populations to get tested for and reveal their HIV status. Minority populations tend to be more religious, which creates stigma around HIV infected individuals. These statements also suggest questions about an individual’s moral character if infected with HIV, which certainly affects decisions to get tested and to reveal sero-status. If you knew that you would be judged and/or shunned, by your community, would you want to tell people about your HIV infection? Would you even want to know your status?

The choice of words here is the strongest aspect of these statements. The fact that the Black male said that an individual “deserves” to be infected with HIV is unbelievable to me. This comment sheds light on the ignorance that exists around the virus. I think that if this student knew how the virus destroys the immune system and leaves an individual to die from a common cold or about the harmful side effects of antiretroviral drugs, he would be less inclined to say that someone “deserves” an HIV infection. I hope so, at least.



During my short time as a volunteer with the non-profit, I also saw the problems with HIV/AIDS-related organizations in general: lack of funding. The van that the outreach coordinator uses to conduct rapid testing has seats in the back and is labeled with the name of the organization, so that people can identify it. During the time that I volunteered, however, this van was broken. All it needed was one part, but the part was very expensive and the organization did not have enough money to pay for it. In the interim period, the outreach coordinator was renting a white van with no seats in the back that was not labeled. One problem with this new van was that the outreach coordinator did not have a comfortable space in which to test people, so his ability to conduct the rapid HIV testing was curtailed. The other problem is that people did not approach the van when the coordinator went on outreach missions, because it was not labeled. This made it difficult to reach as many people as he normally would.

Not only do privately owned prevention organizations face problems with funding, but Federal prevention programs do as well. Many states have reduced HIV prevention budgets because of the economic situation in the country (The White House Office of National AIDS Policy 2010). Besides budget cuts, these programs also have problems delivering the services for the populations that need it most. There is a section of the National HIV/AIDS Strategy document explaining which departments are responsible for HIV prevention and how the funding is split between departments. [See figure 4 below].



[Figure 4 from the National HIV/AIDS Strategy for the United States report by the White House Office of National AIDS Policy, 2010].

According to the pie chart, about half of Federal funding for HIV services comes from Medicaid and Medicare. Two problems with this are that not everyone qualifies for Medicaid or Medicare, and the policies of these programs limit the ability to target certain populations that are more vulnerable to HIV infection (The White House Office of National AIDS Policy 2010).

Further, some locations receive more funding for HIV prevention and treatment than do others, regardless of the amount of people living with or at risk for HIV in each location. The authors of this document explain:

...States with a low number of existing HIV/AIDS cases received the highest HIV prevention funding per case from the CDC. The five states with 50 percent of the persons living with AIDS receive only 43 percent of CDC prevention funds...whereas the twenty jurisdictions that account for

the last two percent of AIDS cases received nearly seven percent of the budget...

Even those programs that do have adequate funds do not allocate them to the appropriate populations. This is clearly a problem for prevention, because if the Federal government is giving money to localities that do not have an HIV/AIDS crisis, the localities that do will suffer. The authors of this document explain that this happens because of old surveillance data, meaning that the CDC is still allocating funds to localities based on their old HIV/AIDS reporting, but I think this might be a cover up. The CDC website has information about populations at risk, and acknowledges the fact that Black Americans had the highest number of new infections for 2009 (Centers for Disease Control and Prevention 2012). Knowing these facts, I cannot rationalize why the CDC would still be allocating funds to localities that do not have high HIV incidence or prevalence.

I feel that the allocation of Federal funds for HIV/AIDS services and treatment demonstrates the political economy of health. Services are denied to the people in this country that need them most. It is becoming increasingly clear that there are segments of the American population that the Federal government cares more about than others. During the HIV/AIDS epidemic, however, the United States government needs to set aside its racist and classist tendencies and focus on saving the lives of its citizens. Otherwise, this is genocide.

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I do not want to paint all HIV prevention programs or organizations in a negative light, however. The organization with which I volunteered does excellent work, notably its needle exchange program, which is highly controversial. When I asked one of my informants, a Black

male, about his opinions of needle exchange programs, he was adamantly against the idea. He said “That’s a horrible idea. We shouldn’t encourage people to do drugs, we should focus on rehabilitation. Giving people clean supplies is just letting them kill themselves cleanly. I am morally against that.” His comment shows one side of the debate against needle exchange programs. My best friend pointed out another argument against needle exchange. I was talking with her after watching a show that discussed a clean needle distribution center for heroin addicts in Los Angeles. My best friend is a very liberal individual, so I was shocked at her statement. She said, “I don’t think we should spend tax dollars on needle exchange programs. If they’re doing drugs already, they clearly don’t value their lives. Why should we spend money trying to prevent them from getting HIV? They’re going to die anyway.” After hearing comments like this, I understand the controversy behind needle exchange programs, as well as the difficulty in accessing funds for such programs. I applaud the organization for its needle exchange efforts, and see this as an important step in the fight against HIV. I think needle exchange programs are crucial, because even if the drug abusers “don’t value their lives,” they have relationships with non-drug abusers, who may indeed value their lives; these are the people needle exchange programs can save. The child of a heroin addict, for example, could be spared HIV infection if needle exchange programs were legal and federally funded.

I want to briefly describe a few other HIV/AIDS nonprofit organizations’ strategies in addition to the one that I volunteered with. One of these organizations is Gospel Against AIDS, a faith-based organization launched in 1997 that provides training and education about HIV/AIDS. The organization has a three component program, which provides the following: AIDS 101, a course on how the virus is transmitted and how it can be prevented; technical

assistance to support the implementation of HIV/AIDS ministries; and referral services to those affected by HIV/AIDS. Gospel Against AIDS works with schools, colleges and universities, hospitals, correctional facilities, and for-profit businesses (Gospel Against AIDS 2003).

Some of the programs of this organization include HIV/AIDS Prevention and Development Training for Religious Leaders, Senior Citizen Education, and Prevention Education for Incarcerated Men (Gospel Against AIDS 2003). These programs are extremely important, especially the programs focusing on religious leaders and on incarcerated men. It is crucial that religious leaders learn about HIV/AIDS and develop the ability to speak about it to their congregations. Incarcerated men are another important target group, because they are extremely vulnerable to HIV infection, but too often left out of the conversation.

Another organization that seeks to prevent HIV/AIDS is the AIDS Foundation of Chicago (AFC). AFC brings services providers and funders together to develop systems that meet the needs of people living with HIV/AIDS, and helps people get case managers (AFC 2011). Further, the AFC promotes strategies to provide safe and affordable housing to people in the Chicago area living with HIV/AIDS. My favorite aspect of the organization is its prevention effort. The AFC has three initiatives that I think are great: the Communities of Color Collaborative, which seeks to provide prevention and care to Black and Latino people; the Female Condom Campaign, which promotes the use of female condoms; and the Faith Responds to AIDS coalition, which is a collaborative of interfaith organizations to prevent HIV/AIDS in the Black community. Lastly, the AFC does advocacy work in Chicago, Springfield, IL, and Washington D.C. to improve services and protect the rights of people living with HIV/AIDS (AFC 2011).

Both of these organizations work directly with the affected communities and the community leaders, so that they can truly make a difference. The AIDS Foundation of Chicago is especially important because it touches on every level of the epidemic: individual, community, and policy.

I see the failings of current types of prevention programs as a major source of the problem in the HIV/AIDS epidemic, but I wanted to hear different opinions. One of my interview questions is “what do you see as the biggest barrier to HIV prevention, and what do you think a successful prevention program would look like?” When I asked this question, my informants noted stigma, lack of education, and the difficulty in changing behavior as the main barriers to prevention. The response that most stood out to me was from one of my White male informants who said, “Pharmaceutical companies are the biggest barrier. HIV drugs are not cheap, and because of that, the majority of the world’s population cannot afford them or have access to them...it is an economic barrier more than anything.” I certainly agree with this belief, and I think that the American HIV epidemic is a perfect example of how flawed the health care system is in this country. The poorest people in the United States suffer the worst health, and thus are the ones who need adequate healthcare the most, but have the most difficulty accessing it.

While my informants listed various barriers to prevention, every person I interviewed mentioned “education” as a successful prevention effort. One of my informants, a White male from a conservative town, noted:

Obviously knowledge and education. I think if people were aware of how it is transmitted, how it can be prevented, and just simple facts about who

it affects and how it affects [that would be] the first step to preventing it. Usually after you see something like that you want to take steps to make sure you don't harm yourself...Education regarding safe sex practices would probably follow...

These comments are interesting because they reveal the individualistic nature of prevention programs that I see as being harmful. Most of my informants believed that giving people information will prevent HIV infection, which often times is not true. I think that the United States society is very individualistic in nature. Many Americans believe in pulling yourself up by your bootstrap and making something out of yourself, which I think contributes to the blame factor of HIV.

Two of my informants, both White females, however, had different opinions. One of the young women, an anthropology major, explained, "What we need is a culturally relevant approach, we need to work with people and not at them." The other young woman, a communications major, said, "We should use messages targeted for different populations." These ideas are very different from those of the male informant I just described. He is a residential advisor in one of the dorms, and talked about the prevention programs that he has done. He noted that the events were most well attended by his Black and gay residents, and thinks that HIV prevention efforts need to be generalized, and not targeted to specific populations.

The fact that only two of my informants noted the need to have messages targeted to different populations, using the community's own norms, echoes the sentiments of many of the

current prevention programs. Many programs today focus on individual interventions, which are not the most effective.



## Conspiracy Theories

In looking at statistics about the populations most affected by HIV/AIDS, including Black and Latinos Americans, I knew that there must be something about them that puts them at higher risks. At the beginning stages of writing this thesis my hypothesis was that individual and collective beliefs about the HIV/AIDS epidemic render successful prevention difficult, possibly infeasible. This hypothesis was supported when I came across research about conspiracy theories related to HIV/AIDS.

Nancy Fraser discusses subordinated populations within the United States, writing:

...members of subordinated social groups – women, workers, people of color, gays and lesbians – have repeatedly found it advantageous to [create]...parallel discursive arenas where members of subordinated social groups invent and circulate counterdiscourses to formulate oppositional interpretations of their identities, interests, and needs... these counter-publics emerge in response to exclusions within dominant publics... (Fraser, 1992:123).

According to Fraser, subordinated members of society create counternarratives to explain their situations. Fraser's article relates to conspiracy theories about HIV/AIDS among people of color and stigmatized members of society. These populations create a type of counter-narrative to explain and describe their reality. Instead of accepting the stigma and blame associated with HIV infection and believing that there is something

wrong with themselves, Black people, for example, create conspiracy theories to explain why HIV/AIDS affects their community at alarming rates.

Further explaining the presence of conspiracy theories is the article *Beliefs in Conspiracy Theories Among African Americans*, by William Paul Simmons and Sharon Parsons (2005). The authors cite John Mirowsky and Catherine E. Ross's 1983 article about distress in order to explain why conspiracy theories are so prevalent within the African American community. Simmons and Parsons write,

They [Mirowsky and Ross] argue that paranoia develops in stages. First, the individual must perceive that his or her life situation is unsatisfactory. Second, the individual, when unable to improve the situation, begins to believe in an external locus of control...This belief in one's own helplessness will combine with the feeling of being exploited in terms of one's own race and class and lead to generalized mistrust; mistrust will then lead to paranoia" (2005:585). According to the authors, mistrust, paranoia, and a feeling of being attacked are the most significant factors in the belief of conspiracies (Simmons and Parsons, 2005:585).

I agree more with this second argument about conspiracy theories. I think that conspiracy theories stem from paranoia and distrust more than anything. While I do not disagree that counter-narratives arise because of a desire to invent an identity opposite of that of the mainstream interpretation of one's own identity, I think that conspiracy theories are more subconscious than Fraser describes them to be. When I asked one of my informants why he thinks conspiracy theories exist, he said without hesitation, "because so many people distrust the

government.” What stands out from this interview is the fact that he believes that the majority of the population, not just marginalized individuals or those who occupy the lowest social strata, distrust the government. This interview led me to agree more with Simmons and Parsons’ explanation behind conspiracy theories, rather than that of Fraser. I still do, however, believe that individuals who occupy the lower social strata are more likely to distrust the government<sup>3</sup>, and therefore are more likely to believe in conspiracy theories.

In an article about HIV/AIDS counter-narratives, Sonja Mackenzie describes the types of conspiracy theories that exist surrounding the HIV/AIDS epidemic: theories that implicate the government’s role in the creation of the virus; theories that define the inaction of the government as genocide; and theories about HIV medications and testing as instruments to wipe out ‘undesirable’ populations (Mackenzie 2011: 491-492). The African American population in the United States has a large number of believers in these types of conspiracy theories, due to a history of medical mistreatment and consequential mistrust of the government. After incidents such as the Tuskegee Syphilis experiments, there is a great mistrust in the government. There is evidence that suggests, however, that this mistrust of science and medicine among the African American community predates the Tuskegee Study, dating back to “antebellum experiments on slaves, of post-war grave-robbing, and of cultural narratives regarding health” (Mackenzie 2011:494).

An example of these cultural narratives regarding health is the sociological study, *The Philadelphia Negro* by W.E.B. DuBois. In this study DuBois writes about the health of Blacks

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<sup>3</sup> The “government” in this chapter refers to both State and Federal United States governments, as well as all of its associated institutions, specifically the medical institutions and agencies.

in Philadelphia, demonstrating the history of poor medical status of Blacks in the United States.

DuBois writes,

...the bad sanitary condition of the Negro quarters on most Southern plantations, there must have been an immense death rate among slaves...One thing we must of course expect to find, and that is a much higher death rate at present among Negroes than among whites...They have in the past lived under vastly different conditions and they still live under different conditions... (1899:148).

This fragment serves as an example of the inequality experienced by African Americans since the beginning of their history in this country. As a result of this injustice faced by Blacks in the United States, medical mistrust of this population towards the United States government and its associated institutions is understandable. Blacks have always, since the first African slave stepped foot in the United States, been mistreated. Even presently, there are more Black males in prison than there are in college. Why shouldn't Black Americans, who are disproportionately affected by the HIV/AIDS crisis, be skeptical?

In a study by Michael W. Ross et al., the authors explore conspiracy theories about HIV/AIDS among four racial groups. Ross et al. writes,

In this study, a higher percentage of Latinos expressed their mistrust of the government and physicians when compared to other ethnic groups.

Approximately 55% of Latinos and 50% of African Americans, for instance, reported believing that the government secretly had an HIV vaccine. HIV vaccine acceptability, in addition, was lower for those who

believed physicians experiment on people without consent (Latinos 38%, African Americans 25%, Whites 15%” (Ross et al., 2006:342).

I must point out that each of the four racial groups, African American, Latino, White, and Asian, reported having believers in conspiracy theories, but that African Americans reported the highest percentage (Ross et al. 2006:343). More importantly, it is only among African American men that belief in conspiracy theories about the origins of HIV was correlated with lower use of condoms (Ross et al., 2006:344). This, in my mind, is the most important finding from this study. While all racial groups report believing in conspiracy theories, it is only among the African American community that these conspiracy theories pose an imminent risk.

While the belief in conspiracy theories surrounding HIV/AIDS is understandable, they have detrimental effects on the communities. The belief in conspiracy theories perpetuates the spread of HIV; individuals who believe that the government created HIV to target certain populations are wary of public health precautions and therefore do not take the necessary steps towards prevention, thus spreading the virus among the community, encouraging more individuals to believe in the conspiracy theories and repeating this cycle. Unfortunately, however, it seems that this cycle is only, or mostly, present among the Black population in the United States.

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As Ross et al. demonstrate, African Americans are not the only members of society who believe in conspiracy theories. Mackenzie also discusses that one third of Native American women and men who have sex with men believe in a White institutional origin for HIV (Mackenzie 2011:495). Further, Mackenzie notes a study that sampled men who have sex with

men, citing that 86% of these men agreed with one or more conspiracy theories about HIV/AIDS (Mackenzie 2011:494). These statistics serve as further evidence that individuals that occupy the lowest levels of the social hierarchy are more likely to believe in conspiracy theories, because of their negative experiences with the government and its institutions.

In a discussion about conspiracy theories among Latinos, Ross et al., explain the source of mistrust among this, and other, communities. The authors write:

Latinos in Texas have historically suffered racism: in the history of Texas, there were more Mexicans lynched than African Americans and this type of oppression becomes part of the collective consciousness of a people. Mistrust can be generalized to other institutions<sup>4</sup>...In the United States, African American, Puerto Rican, Chicano, indigenous, and poor women have been more likely to be sterilized than White women from the same or higher socioeconomic classes. Women with physical disabilities whom physicians judge to be “unfit to reproduce” have also been sterilized since the eugenics movement in the late 1920s...Sterilization abuse was so common among African American women in the South that a woman’s having her fallopian tubes tied or uterus removed without her knowledge or consent was called the “Mississippi appendectomy”...Chicano women were being sterilized immediately after giving birth (Ross et al. 2006:344).

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<sup>4</sup> What is important here is that mistrust of everything that comes from White Americans is lumped under the “government” umbrella. For example, the Latinos in Texas were not lynched by government officials, but were lynched by White Americans, who are the same as the government in the eyes of the oppressed victims.

With all of these reports of abuse of individuals of color, it makes sense that members of these communities would believe in conspiracy theories. After having been so systematically mistreated time and time again, how can these individuals believe anything produced by the government and its institutions, especially the medical establishment? If I had witnessed my mother, or aunt, or grandmother, or father, or brother, or sister, or cousin, be lynched or sterilized at the hands of the United States government, I would not believe anything that this sector produced or sponsored about healthcare.

I became curious about the arguments of people who believe in conspiracy theories about HIV/AIDS, so I read the book, *Queer Blood: The Secret AIDS Genocide Plot* by Alan Cantwell to understand. Cantwell compares the HIV/AIDS epidemic amongst the homosexual community to the Nazi genocide in Germany. According to Cantwell, a Polish doctor Wolf Szmunes held an experiment in 1979, during which he administered a vaccine for hepatitis B, mostly to gay men (Cantwell 1993:18). In 1980, Szmunes extended the experiment to subjects in San Francisco, Los Angeles, Denver, St. Louis, and Chicago (Cantwell 1993:18). Cantwell claims that Szmunes, knowing that the vaccine contained a sexually transmitted disease, selectively chose promiscuous, homosexual men who would spread the disease to as many men as possible (Cantwell 1993:17). As the first reported AIDS cases appeared in 1981, Cantwell believes that the hepatitis B vaccine was the cause, and that HIV is a man-made virus. I do not doubt why Cantwell, a gay male physician, would be skeptical about the AIDS epidemic, as he watched his peers die from AIDS in the 1980s. I do think, however, that his conspiracy theory is dispensable. Even if the government did purposely infect certain populations, we know how the virus can be

prevented. What matters now is that we work to prevent the spread of HIV, not worry about where it came from.

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In my interviews, eleven informants talked about at least one conspiracy theory that she or he has heard about the HIV/AIDS epidemic. Four informants mentioned the theory that the US government had a role in the creation of the virus. Two of these four disagree with the theory, and one does not know what to believe about the origins of HIV. The informant who is undecided about the origins of HIV, a Black male, does not believe that the US government played a role in the creation of the virus. When I asked this question he responded, “That’s a theory that people might run with, but I don’t believe it. I can see the introduction of crack as population control, I can see the links there, but not with HIV.” My informant believes this because the introduction of crack allowed the government to begin the “war on drugs” and imprison Black males, but does not believe that the US government would purposefully kill citizens.

When I asked one of my White female informants if she has heard any conspiracy theories she said no, but said that she “wouldn’t be surprised” if the government is using HIV as a method of population control. She said, “that would be horrible, but I could believe it.”

A White male that I interviewed said he has heard the theory that the CIA created HIV to kill Africans in order to make it easier to extract resources from the continent. He also says that his father believes that AIDS is a conspiracy because HIV is the “perfect” virus because it attacks the immune system, and had to have been man-made.



Another white female that I interviewed said that she could implicate the pharmaceutical companies in the HIV epidemic in the United States because of the expense of antiretroviral drugs. She believes that researchers may not be trying to find a cure because the pharmaceutical companies make so much money from the HIV drugs, but does not believe that the government created the HIV virus.

Only one of my informants, a University of Michigan alumnus, truly believes in a conspiracy theory. This informant, a 40 year-old White male, believes that Ronald Reagan contributed to the epidemic when he let Cuban immigrants settle in Miami. He said “Reagan let all of the undesirables into this country. That contributed to the epidemic.” When I heard this, I could not help but think that my informant has watched *Scarface*<sup>5</sup> too many times. This is certainly a new conspiracy theory that I have never encountered. My informant was referring to the Mariel Boatlift, the 1980 immigration of approximately 125,000 Cubans, and Reagan’s inheritance and resettlement of these persons that led to a seven percent increase in the population of Miami (David Card 1989:2). This informant is under the impression that most of the Cuban immigrants were criminals or patients of mental institutions, but there is insufficient data to support or reject his claims (Card 1989:8). Further, there were several hundred immigrants who were detained in the United States and deported back to Cuba (Card 1989:8), so I am skeptical to jump on this bandwagon and point blame at the Cubans.

Although only one of my informants believes in any conspiracy theories, the fact that the majority of my informants have heard one or more conspiracy theory reveals how widespread these theories are; even the most educated individuals have encountered them. This has negative

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<sup>5</sup> This 1983 film, directed by Brian De Palma, depicts the life of Tony Montana, a Cuban immigrant to Miami. Montana becomes the leader of a drug cartel, selling massive amounts of cocaine within the United States.

implications for the rest of the population. Although my informants, likely because of their educational achievement, are skeptical of these theories, the adult population at large, especially individuals within minority populations, may not be as skeptical and will believe these theories, which surely creates an obstacle for the prevention of HIV.

I understand how members of marginalized populations in this country believe in conspiracy theories about HIV/AIDS. As an educated individual, I disagree with these theories, but in looking at the history of these populations in the country, and because of my own membership within the Black American community, I do believe that there is some merit to these beliefs. When I witness my Black male friends being harassed by the police while we are walking towards the subway, or when my father tells me about having been chased by New York City police officers with baseball bats during the 1960s, or when I think about the US government's response to Hurricane Katrina, I can't help but be skeptical of the government myself.

With all of that said, I feel that direct action needs to be taken to dispel these conspiracy theories and overcome the barrier to prevention of HIV/AIDS that they pose. While I do understand skepticism of the US government and belief in conspiracy theories, the fact of the matter is that individuals are dying needlessly because of this epidemic and their own mistrust in the systems in place to prevent the spread. I have heard people say that if AIDS killed mostly White, middle class males in the United States, the government would be doing more about it. This very well may be true, but AIDS is not killing these individuals; it is killing Blacks, Latinos, and homosexuals at alarming rates and something needs to be done immediately. My anthropology-minded brain wants to say that public health officials need to create culturally

relative interventions, working with the populations, but the skeptic in me doubts that even that strategy will work. Members of high-risk communities already distrust the medical establishment; I doubt that even the most meticulously planned, culturally relevant intervention at the hands of any member of mainstream society will be effective. The change needs to come from within. Black, Latino, and homosexual leaders and community organizers need to be at the forefront of the cause, changing adverse behavior and encouraging members of their communities to take control of their health. I am a big fan of the Black AIDS Coalition, run by Black people in order to help Black people combat the HIV/AIDS epidemic. I think that there need to be more organizations like this among the high-risk populations of the United States. I'll be the front-runner for Black females in the fight against HIV/AIDS.

## Media

*This is the tipping point we have been campaigning for. We're nearly there. – Bono*

In an op-ed article in the New York Times, Bono, lead singer of the band U2, wrote this quote. He continued, “today, here we are, talking seriously about the ‘end’ of this global epidemic....New research proves that early antiretroviral treatment, especially for pregnant women, in combination with male circumcision, will slash the rate of new HIV cases by up to 60 percent” (Bono 2011). Bono neglects to mention the expense and difficulty in access of the antiretroviral drugs because of structural violence and systemic inequality that exists. HIV infected individuals have difficulty adhering to drug treatment regimen because clinics are often far away, because the drugs are too expensive, because unstable housing inhibits adherence to drugs that need to be refrigerated, and/or because of the overall instability of daily life in impoverished areas.

Bono also oversimplifies the problem, not mentioning the social and behavioral factors that influence the spread of HIV that render “the end of the epidemic” extremely difficult. For example, while male circumcision decreases risk of HIV infection in men, it is not a common practice among many cultures. Bono’s article focuses on AIDS in Africa, but neglects to mention cultural traditions in African nations such as Nigeria, where male extra-marital affairs are common and accepted.

Bono does, however, leave the American reader satisfied by the end of the article, making her feel that America has heroically done its part to “end” the AIDS epidemic. Bono credits American leaders such as George W. Bush and Bill Clinton for starting the “beginning of the end of AIDS,” and continues:

“George W. Bush, leading the largest ever response to the pandemic...Bill Clinton, arm-twisting drug companies to drop their prices; Hillary Rodham Clinton, making it policy to eradicate transmission of HIV from mother to child...And then there were the everyday, every-stripe Americans. Like a tattooed trucker I met off I-80 in Iowa who, when he heard how many African truck drivers were infected with HIV, told me he’d go and drive the pills there himself. Thanks to them, America led. *Really* led. [emphasis his]” (Bono 2011).

Information like this is dangerous to the HIV/AIDS epidemic, because it leaves the average American reader under the impression that AIDS is under control and that there is no threat anymore. Never mind that globally there are still over a million AIDS-related deaths each year. Never mind that there are rates of HIV up to 5% in some parts of the United States. Never mind that George Bush’s “largest ever response,” the President’s Emergency Plan for AIDS Relief (PEPFAR) emphasized abstinence and overlooked the more practical and culturally relative emphasis on condom use. Bono *really* failed the American public with this article.

Bono is also the founder of the (Product)RED campaign, a campaign dedicated to fighting AIDS in Africa. The (RED) campaign describes its process as such, using the Gap store as an example:

1. A shopper notes that the Gap (PRODUCT)RED apparel costs the same as other Gap apparel. But choosing the (RED) clothes means 50% of Gap’s profits will go to help eliminate AIDS in Africa.

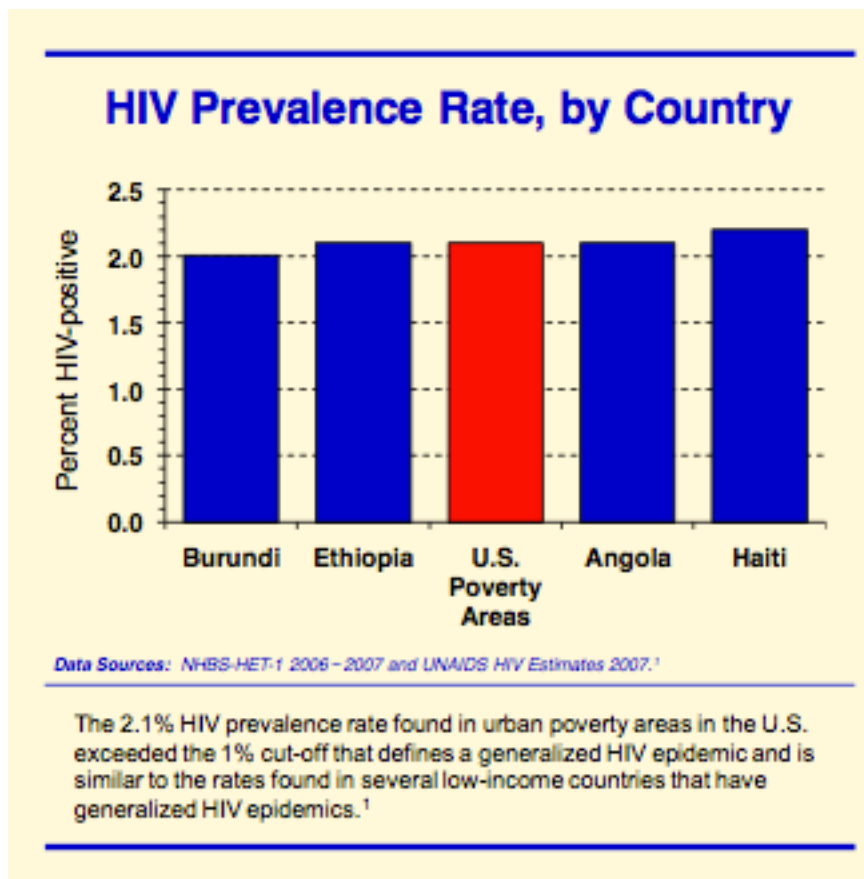
2. Shopper buys the Gap (PRODUCT)RED apparel. Gap sends a contribution of profits directly to The Global Fund. 3. The Global Fund uses 100% of this money to finance HIV health and community support programs in Africa, with a focus on women and children. 4. The contribution helps a person affected by HIV in Ghana, Swaziland, Rwanda, Lesotho, Zambia, South Africa and other countries to be granted (RED) money in the future (Join RED 2012).

This is a great idea, in theory. My problem with a campaign like this is that it solely focuses on the AIDS epidemic in Africa. This campaign, in my mind, perpetuates the stereotype that AIDS is an African epidemic. Further, the campaign website offers no information about HIV/AIDS, prevention techniques, or facts about HIV/AIDS anywhere but in Sub-Saharan Africa. If the RED Campaign website is the only source of information for American people, they would be grossly misled about the reality of the HIV/AIDS epidemic.

On the “facts” page of the campaign website it notes that “It costs around 40 cents a day for the 2 antiretroviral pills needed to help keep someone living with HIV alive and healthy” (Join RED 2012). This is false. The best treatment is a combination of at least three drugs, some of which must be taken more than once daily. Further, the HIV virus is very prone to mutation, so an individual usually has to change her drug regimen several times throughout a lifetime of infection, and sometimes no drugs can treat the strain she has. The Join RED website simplifies the true biology of the virus and its treatment.

While the majority of AIDS cases in the world are on the continent of Africa, I feel that the RED campaign, and others like it, does a disservice to Americans living with HIV/AIDS.

The message of this campaign implies that the only people who need help are individuals in Africa, which is absolutely untrue. There are impoverished urban cities in the United States that have higher rates of HIV than do some nations within Africa [see figure 5]. Washington D.C., for example, has a three percent HIV infection rate (Susan Koch 2010), but no media campaigns mention this fact. The majority of campaigns and advertisements against HIV/AIDS focus on the African continent.



[Figure 5. From *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?* By Paul Denning, MD, MPH and Elizabeth DiNenno, PhD. 2010. Sponsored by the Centers for Disease Control and Prevention]

This graph, from 2007, reveals alarming evidence that the rates of HIV infection in the United States are above or around the same as those of rates in developing nations. Burundi, for

example, had a rate of HIV prevalence, the number of people living with HIV, lower than that of urban areas in the United States. Why then, do media campaigns focus on AIDS in Africa? How many more people need to die in the United States before HIV/AIDS becomes a priority here?

Another campaign that I stumbled upon is MTV's Staying Alive Campaign. The campaign started in 1998, when Georgia Arnold made the 'Staying Alive' documentary. Essentially, the Staying Alive Campaign is a social media campaign that promotes HIV preventing behavior. The Staying Alive Campaign consists of documentaries, public service announcements, blogs and forums for the public, and an internet drama series called Suga: Love, Sex, Money, focused on people in Kenya trying to prevent HIV. The campaign has bloggers who write about safe sex and reducing stigma, as well as members of the team who promote condom usage and HIV prevention information via twitter (MTV International 2009). The Staying Alive Campaign is a collaboration between MTV International, UNAIDS, UNICEF, and PEPfAR (MTV International 2009).

This campaign could be extremely beneficial if it were more widespread. I first heard about the campaign from the professor of my Global AIDS Epidemic course. I asked a few of my friends, but nobody had ever heard of this campaign before. This is supposed to be a global campaign, but the internet drama series focuses on preventing HIV in Kenya; again following the stereotype of AIDS being an "African disease." For this campaign to truly have an impact, it needs to focus on HIV/AIDS throughout the world, not just within one African country. I do realize that the campaign is run through MTV International, but I feel that the lack of presence within the United States is a problem. I cannot help but wonder why the MTV channel that we watch in the United States, run by Viacom, does not feel the need to promote the Staying Alive Campaign in this country. The message that MTV is sending is that only people in other



countries need to worry about HIV/AIDS, which is untrue. I think that Viacom is doing a disservice to the American youth population by not promoting the Staying Alive Campaign, or any HIV/AIDS prevention media, in this country.

I do not wish to bash all media campaigns, because I do think that mass media could be a powerful tool to fight HIV/AIDS. A few of my informants echoed this sentiment, believing that targeted media messages could help prevent HIV infection within the United States.

When I asked what a successful prevention program would be, one informant, a White female studying communications, said,

I think that a great idea would be to do something, of course this goes along with the digital divide and socioeconomic status, but putting something online, like a marketing campaign online would reach a large amount of people...or billboards on random highways in the middle of nowhere saying AIDS exists here, maybe saying what HIV is on the billboard...maybe there should be a really big PBS special, and there should be a PSA, and Obama should say something...he's the President, people would listen.

I certainly agree that President Obama, as well as other government officials, should take more action against HIV/AIDS in the United States, and that there should be more media attention about the epidemic within the country.

Another informant who spoke about the media talked about the role of the media in decreasing stigma. This person, a White female studying anthropology, said, “[the media

should] Make it seem more so...it's not going to be a stigmatized disease, make it seem like a disease that everyone can get and everyone should be tested for." I think that this is probably the most important thing that the media can do. Stigma is a barrier to prevention of HIV in the United States, and media attention that normalizes the virus would alleviate the stigma and help decrease the spread of HIV.

While some of my informants believed that media campaigns could be helpful, one individual, a Black male, made me aware of the sense of apathy that can come from such campaigns. I asked this informant about why people don't talk about HIV/AIDS, to which he answered, "Because there are commercials about it. Like the BET commercials, those do enough, we don't have to talk about it." My informant was referring to the "Rap It Up" campaign by Black Entertainment Television and the Kaiser Family Foundation that "takes a cross-platform approach to distributing information, dispelling popular myths and misconceptions, reducing stigma and discrimination, and increasing HIV testing" (Kaiser Family Foundation). These commercials have Black people in every day situations discussing the need to get tested, or to disclose your HIV status to sexual partners. I do think that "Rap It Up" has been an important tool, but was disappointed to hear my informant say that we as individuals do not need to speak on the subject because BET does so. I doubt that his opinion is unique, unfortunately; there are likely many others who feel that the responsibility of speaking out against HIV/AIDS should and does fall upon leaders and celebrities.

One such celebrity is Magic Johnson. Magic announced his HIV infection in 1991, and has been living with the virus since. In an article about his life, Rupert Cornwell of *The Independent* writes, "The temptations for idolized superstar athletes who spend so much of their

career away from home are well known, and Magic by his own admission succumbed to more than his fair share. In his case, the consequences were calamitous” (Cornwell 2012). I want to highlight this section of the article because it serves as an example of the blame placed on individuals with HIV. The author writes that Magic Johnson was infected because he succumbed to temptation. This opinion adds to the stereotypes about people with HIV, and implies that you must have done something wrong to have contracted it.

I don't want to focus only on this blame placed, however. The most important part of this article is the section in which the author writes, “His business interests...are worth some \$700m...Johnson is proof that even when infected with HIV, a person can lead a full and productive life...Johnson's success may have lessened the spotlight on AIDS, creating an impression that it has gone the way of smallpox and polio” (Cornwell 2012). This is the image that is detrimental to the prevention of HIV. When people look at Magic Johnson and read about his life, they begin to believe that HIV infection would not be that bad. People see his net worth, see that he looks healthy and is still a productive member of society, and believe that they can live a productive life as well. What people neglect to realize is that HIV medication is extremely expensive, and that Magic Johnson has the resources to afford the most effective treatment. People also neglect to mention that as a professional athlete, Johnson likely had a stronger immune system than most. Lastly, people do not mention the fact that Magic Johnson started treatment soon after he found out about his infection; this made the anti-retroviral medication more effective in his body and better able to combat the infection.

One of my informants, a White male pharmacy student, said, “Magic Johnson was a good instance where it was publicized but that's probably been long forgotten, because people probably see him on tv and think he's been cured of it.” While Magic Johnson was a figure in

the media who was helpful in combating the stereotype of AIDS being a gay disease, his health can lead to a sense of apathy about the virus. When people see Magic Johnson living a productive life and looking healthy, the fear of HIV/AIDS begins to decrease.

I became convinced of this fact after a personal experience. On the flight back to school after spring break, I was reading a book about the HIV epidemic in the United States. I had a conversation about the epidemic with the man sitting next to me and he said, “AIDS is pretty much a chronic illness now, isn’t it? I mean, you can live a fine life having it.” With attitudes like this, people are less likely to prevent themselves from HIV infection, because they believe that they can “live fine lives” with an HIV infection.

In addition to Magic Johnson there is other popular culture media surrounding HIV/AIDS. Donald Glover, a rapper/actor, delivered a stand-up comedy sketch entitled *Weirdo*, during which he spoke about AIDS. Glover said, “I’d much rather have AIDS than a baby...they’re both expensive, you have them for the rest of your life, they’re both constant reminders of the mistakes you made, and once you have them you pretty much can only date someone else who has them.” (Donald Glover 2012). While this may have just been a joke, I think that it can be harmful to people who know nothing about HIV/AIDS. If this is the only source of information about AIDS that people get, they can be sadly misled to believe that AIDS is not that big of a deal and that having children would in fact be worse. Glover did not talk about the effects of HIV/AIDS within a human body, so the members of his audience who do not know anything else about the virus may not take preventative measures.

Donald Glover is not the only entertainer to speak about HIV/AIDS. Kanye West, a well-known rapper and producer, briefly discusses AIDS in his song *Gorgeous*. West raps “I treat my cash the way the government treats AIDS / I won’t be satisfied ‘til all my n\*\*\*\*s get it”

(Kanye West, *My Beautiful Dark Twisted Fantasy* LP 2010). West, in his explicit line, alludes to the fact that HIV/AIDS is a problem that affects Black people in this country. Through a certain lens I see this line as an agreement with the conspiracy theory that the federal government is not concerned about HIV/AIDS in this country because it kills Black people (and other marginalized populations) at alarmingly high rates. I am conflicted about this line in his song. I am a fan of Kanye West, and am glad that he made a statement about the HIV/AIDS epidemic in the United States, but I worry that he is contributing to the belief in conspiracy theories. My fear is that individuals in this country who do not have any source of information about HIV/AIDS besides this Kanye West song will believe that the government is giving Black people AIDS. On the other hand, this lyric may get Black people thinking about the HIV/AIDS epidemic in this country, starting an activist movement towards prevention. This line in West's song reveals the complexity of media representations of the HIV/AIDS epidemic; it could be a catalyst for prevention, or it could contribute to stereotypes and conspiracy theories.

Another media representation of AIDS is the movie *Philadelphia*, directed by Jonathan Demme, starring Denzel Washington and Tom Hanks. In this 1993 film, Tom Hanks plays a gay, HIV positive lawyer who is fired because of his infection. Denzel Washington plays the role of Tom Hanks' lawyer in his wrongful dismissal suit against the law firm. One of my heterosexual male informants mentioned watching this movie and stated that this contributed to his image of HIV infected individuals as being gay. Every single informant that I interviewed mentioned the stereotype of HIV being a gay disease, and I think that films such as *Philadelphia* perpetuate this image.

I must point out two facts about this movie, however. The first is that the film was made in 1993, when HIV/AIDS still mostly affected white gay males. With that said, it does make sense that the film would focus on a gay white lawyer with HIV. The other is that in the movie Tom Hanks was visibly ill, and I believe that the director was accurate in his depiction of a person living with HIV. Tom Hanks lost a great deal of weight throughout the movie, had skin lesions known as Kaposi Sarcoma, and had difficulty breathing because of pneumonia. All of these conditions are characteristic of an HIV infection, so I must credit the director for this. My informant explained to me that some of what he learned about “how bad an HIV infection is” came from *Philadelphia*. This is not the only fictional movie to depict HIV. Another example is the movie *Kids*, directed by Larry Clark.

*Kids* follows a group of adolescents in New York City on one summer day. One of the characters, a teenage male, is obsessed with sex, especially sex with virgin females. On this one particular day, he has sex with two virgins. Not surprisingly, he is infected with HIV, and has infected both females. This depiction of HIV is problematic because it goes along with the stereotype of promiscuous people being infected with HIV. When I asked my informants stereotypes they had heard about HIV, almost every one mentioned that people who get HIV have had sex with many people. Further, all of the teenagers in the movie were of the working class, which goes along with another stereotype that I heard frequently: people of low socioeconomic status get infected with HIV.

Each of the media outlets I described touched on one of the stereotypes I discussed in the previous section, which is problematic. The use of mass media, including, television, movies, and internet sources, could be an extremely useful tool in the fight against HIV/AIDS in the United States, but has not lived up to its full potential. According to a document from UNAIDS,

72% of Americans identify television, radio, and newspapers as their main source of information about HIV/AIDS (The media and HIV/AIDS 2004). While the education system may be failing American youth and not reaching American adults, the media could be a powerful resource.

In a book about the media's influence, Karen Dill explains, "...the average U.S. citizens spends 3,700 hours per year using mass media. If you are like the average person, you spend about two-thirds of your waking hours using media in one form or another" (Dill 2009:6). This is a ridiculous amount of time spent consuming mass media; I have no doubt that media message about HIV/AIDS would help prevent, or at least make people aware of, the HIV epidemic. Dill continues to explain how the media is so impactful, writing:

Studies have shown that if you build false information into a fictional narrative, people actually come to believe the false information...People reading a book, watching a movie or TV show, or playing a video game become transported, swept up, or lost in the story...when a fictional story transports us, we are persuaded rather uncritically because transportation decreases counterarguing (questioning assertions) and increases connection with the characters and the sense that the story has a reality to it...we have suspended our disbelief, and this facilitates our persuasion... (Dill 2009:13-14).

Mass media has a sort of hypnosis effect over us; we believe what we see. If there are positive images and/or information about HIV/AIDS in the media, Americans would certainly think about the epidemic more and would believe the positive images that are broadcasted.

The problem, however, is that representations of HIV/AIDS have decreased in the past decades (Kaiser Family Foundation, see Appendix), and those representations that do exist tend

to perpetuate stereotypes. Dill later discusses the impact of stereotypes in media sources. She describes a video game in which African American men were portrayed as thugs and White men were portrayed as vigilantes and soldiers. In her experiment, she observes how White participants respond to violent objects and nonviolent objects. Dill writes, "Results showed that participants responded faster to the violent objects after seeing African American male video game characters and faster to the nonviolent objects after seeing White male video game characters" (Dill 209:95). Her experiment reveals how detrimental negative stereotypes truly are. After seeing the negative stereotypes of Black men and positive images of White men, the participants held on to these representations and applied them to other situations. The same goes for representations of HIV/AIDS. When people see stereotypical images of people with HIV or AIDS, these negative ideas become facts engrained in their minds.

When the media outlets begin to impart knowledge and stop perpetuating negative stereotypes about HIV/AIDS, it will be an effective tool. As of now, however, I view the media in a negative light, and think that it is hindering the prevention of HIV.



## Conclusion

This thesis has described the social factors, the structural violence and the political economy of health that contribute to the HIV/AIDS epidemic in the United States. Producing this work has been challenging but rewarding. I am pursuing a Master's degree in Health Behavior next year, but learning about the HIV/AIDS epidemic has made me aware of the shortcomings of public health interventions. While changing individual behavior is essential, more than anything, structural and policy changes need to be implemented to the health care system in order for the epidemic to end. The government also needs to create structures that will attempt to diminish disparities in health experienced by marginalized populations in this country.

In the beginning of this thesis I wrote that the political economy of health in this country will contribute to create a permanent lower class of citizens who experience higher morbidity and mortality. I want to briefly expand on this, and go so far as to say that the racism inherent in the political economy of health *creates* biological race in this country. Even though the races are genetically similar, biological differences are beginning to appear. While the term race is known to be a cultural construct, it is embodied as a result of experienced racism (Gravlee 2009). In an article about racial disparities in health, David H. Chae et.al explain the socio-psychobiological approach to understanding disparities in health. The authors write,

...a socio-psychobiological approach explicitly posits that racial disparities in health are reflections of underlying social inequalities, expressed in inequitable relationships of dominance and oppression, and privilege and deprivation – not only with regard to material resources, but also in terms of other forms of social power...ideological hegemony is

the dominance of ideas, beliefs, and culture, and contributes to the reification of oppressive social structures...(Chae et.al 2011:68).

This approach sums up how the HIV/AIDS epidemic has spread so rapidly within the Black community specifically. While psychological and social factors, such as stigma and homophobia, undoubtedly contribute to the epidemic, the structural racism experienced by Black Americans, including housing and educational segregation and unequal access to health care, exacerbates the HIV/AIDS epidemic in this population. Chae et.al also explain how experienced racism has deleterious effects on mental health and causes maladaptive health behavior, including drug abuse and heavy drinking (Chae et.al 2011:70). In addition to the structural racism that negatively affects Black Americans, day-to-day racist experiences leave members of this community under more psychological stress, which is found to increase biological vulnerability to disease (Chae et.al 2011:70).

This process of racialization is not recent, however. Racialization began with slavery, when Black people were forced to live in sub-standard conditions, and has continued throughout history, as evidenced in W.E.B. DuBois' piece about Blacks in Philadelphia. As a result of the reification of oppressive structures and increased vulnerability to disease, a biological race is being created. The HIV/AIDS epidemic is simply one example of this racialization. Black Americans males, for example, are more likely to be incarcerated, which leaves them at risk for HIV infection. Once released, they infect their female partners, who, because of structural injustice, have difficulty accessing adequate healthcare, and as a result, infect their newborn children with HIV. If the structural violence does not end, this cycle will continue, with Black

Americans (and other marginalized populations) continuing to experience worse health outcomes and higher mortality.

In addition to the structural changes that need to be made, the psychological and social factors need to be addressed in order to prevent the continuation of the HIV/AIDS epidemic in the United States. The rest of this section will address such factors.

### **Increasing Positive Media**

UNAIDS reports that 72% of Americans identify the media as their primary source of information about HIV/AIDS (The media and HIV/AIDS 2004). With this high of a percentage, the media needs to take a more active role in disseminating information about HIV/AIDS to prevent the spread. The media especially needs to emphasize the fact that HIV/AIDS is a problem within the United States, and is not an “African disease.” One example that the US media can draw on is from Tanzania. A radio soap opera series called *Twende na Wakati* has increased individuals’ willingness to discuss HIV/AIDS, and it is reported that more than 8 in 10 people have adopted HIV prevention behaviors because of listening to the show (UNAIDS 2004).

In addition to simply breaking the silence about HIV/AIDS in the United States, the media can serve as a tool to decrease stigma and normalize the virus. For example, the main character on South Africa’s version of *Sesame Street* named Tami, the Tswana word for acceptance, is HIV positive. There have been episodes in which Tami has been discriminated

against in school but has taught her classmates about acceptance (UNAIDS 2004). I think that having HIV-positive characters on television shows for children is an excellent way to reduce the stigma and normalize the virus, starting at an early age.

It is imperative that media attention to HIV/AIDS is on mainstream channels, so as to reach the largest number of people possible. While there certainly are ads on Black Entertainment Television (BET) promoting HIV testing, for example, there need to be commercials and programs that are targeted to the American population in general, on channels such as MTV and in popular magazines. General messages are also important because they will reduce the thought that HIV/AIDS is an “other” problem if they appear everywhere. If only BET has commercials about HIV/AIDS, a large sector of the population will not see them, and/or will believe that the epidemic only touches that community.

### **Reduction of Homophobia**

Accepting homosexuality is another step towards preventing HIV/AIDS in the United States. I believe that most of the homophobia in this country is a result of religious beliefs, or at least is justified on religious grounds, therefore churches could play an instrumental role in decreasing homophobia.

Krista McQueeney describes two churches that do exactly this, Faith Church and Unity Church (McQueeney 2009). McQueeney describes Faith Church as a “60-member evangelical congregation in a midsize Southern city attended primarily by working class black lesbians” with a Black lesbian pastor (McQueeney 2009:154). The other church McQueeney studied was Unity Church, a “550-member, predominantly white, middle-class, liberal Protestant church in a

southeastern university town...Unity was a mostly heterosexual, family-oriented congregation...[with] three pastors: a white heterosexual couple...and a white lesbian associate pastor (McQueeney 2009:155). According to the author, both churches affirmed same-sex couples through holy union and normalized sexual identity, erasing the stigma associated with homosexuality (McQueeney 2009:159).

More churches, especially Black churches, need to take a lesson from Faith and Unity Churches in reducing homophobia. When pastors begin to accept homosexuality, homosexual individuals will be less likely to experience the negative effects of homophobia, including risky sexual behavior and psychological distress. Further, when homophobia is reduced, I believe that gay individuals, specifically Black people, will be more likely to organize and fight for their rights, much like gay men did in the beginning of the American AIDS epidemic. Additionally, when homosexuality is more widely accepted, I believe that conversations about HIV/AIDS will be easier and more frequent, because some of the taboo factor will have been erased.

### **Expanding Accessibility to Treatment and Services**

Besides combatting social factors, making HIV treatment widely accessible is the best way to prevent the spread of the virus. An example of a country that has done this is Brazil. While it may seem odd to take lessons from a developing nation, the United States certainly can learn from this country. Brazil provides antiretroviral (ARV) treatment to all HIV-infected people, through the public healthcare system, for free. Brazilian pharmaceutical companies make the drugs in the country, which erases the cost of importing these drugs (Jane Galvão 2005:1110).

There is absolutely no reason why the United States could not do this. Major pharmaceutical companies that manufacture ARVs, such as Merck and Pfizer, have headquarters in the United States; there is no cost of importing these drugs. What is stopping these companies from selling antiretroviral drugs at affordable prices? While there is no public healthcare system to provide the drugs for free, reducing the price of these drugs is feasible. This discussion reveals the deeper-seated issue in this country: healthcare has become a for-profit sector, instead of focusing on delivery of treatment and improving the quality of human life. Pharmaceutical companies want to sell their drugs at exceedingly high prices, and private insurance companies do not want to pay for the drugs, both in order to maximize profit. According to the World Health Organization assessment of costs of ARVs, these drugs really only cost approximately \$3700 a year (World Health Organization 2010). These large companies are concerned about themselves, leaving the people in need vulnerable. Pharmaceutical and private insurance companies need to realign their priorities and decrease the costs of ARVs. The government should place a cap on the price of prescription drugs, and if Obama's healthcare plan passes, the government health insurance company should pay for life-saving drugs for its recipients.

In addition to treatment, services for people living with HIV/AIDS need to be made more widely available. In an article about the need for adequate housing for people with HIV or AIDS, James Wortman explains how inadequate housing worsens an HIV or AIDS infection and the types of services that are needed to improve the lives of people living with HIV or AIDS. I want to highlight one example that Wortman cites. The author explains that New York City and New York State housing legislation does not provide housing assistance to HIV infected people until they progress to a full-blown AIDS infection. Wortman continues to describe an HIV positive woman who entered a non-profit organization that helps provide housing to HIV/AIDS

infected people, called Housing Works, and asked the director to pray that she has AIDS by the winter time so that she can get a house. At the time, the woman was homeless and was living under a tractor trailer (Wortman 2008:32). The system of services for people living with HIV is so flawed that individuals *want* to have AIDS, which will kill them, in order to receive assistance. Federal and state governments need to provide better housing assistance to people living with HIV or AIDS.

### **Services for Marginalized Populations: Injection Drug Users and Prisoners**

While these are controversial ideas, I firmly believe that federal funding toward needle exchange and sterilizing programs, as well as providing condoms in prisons, will decrease incidence of HIV. In a study about drug abusers in Connecticut, C.B. McCoy reported that injection drug addicts use needles that have been used on average 4.4 times (C.B. McCoy et al. 1997:52). Further, M. Singer et.al indicate that the presence of needle exchange programs can reduce the chance of HIV infection among injection drug users between 30 to 80% (M. Singer et al. 1997:128). The sharing of needles is the most efficient way to spread HIV, as an individual is directly injecting infected blood into his bloodstream. If clean needles can prevent HIV infection, there need to be programs to provide users with clean needles, as well as bleach to clean their other instruments, such as glass pipes used for smoking drugs.

Services to prisoners will also be helpful in the fight against HIV/AIDS in the United States. Stacy E. Christensen, a professor of nursing, writes about HIV testing policies in prisons, explaining, "According to the most recent U.S. Bureau of Justice report, the number of HIV-infected individuals living in the United States who are incarcerated is approximately 2.5 times

higher than that of the general population” (Christensen 2011:238;Maruschak 2009).

Christensen cites another study, reporting that 25% of inmates had consensual sex while incarcerated (Christensen 2011:238;Hensley 2001). These statistics are extremely problematic, given that condoms are prohibited in United States prisons. In order to prevent the spread of HIV in federal and state prisons, the prison systems need to provide condoms, as well as needle exchange programs for the prisoners.

### **Practical Sex Education**

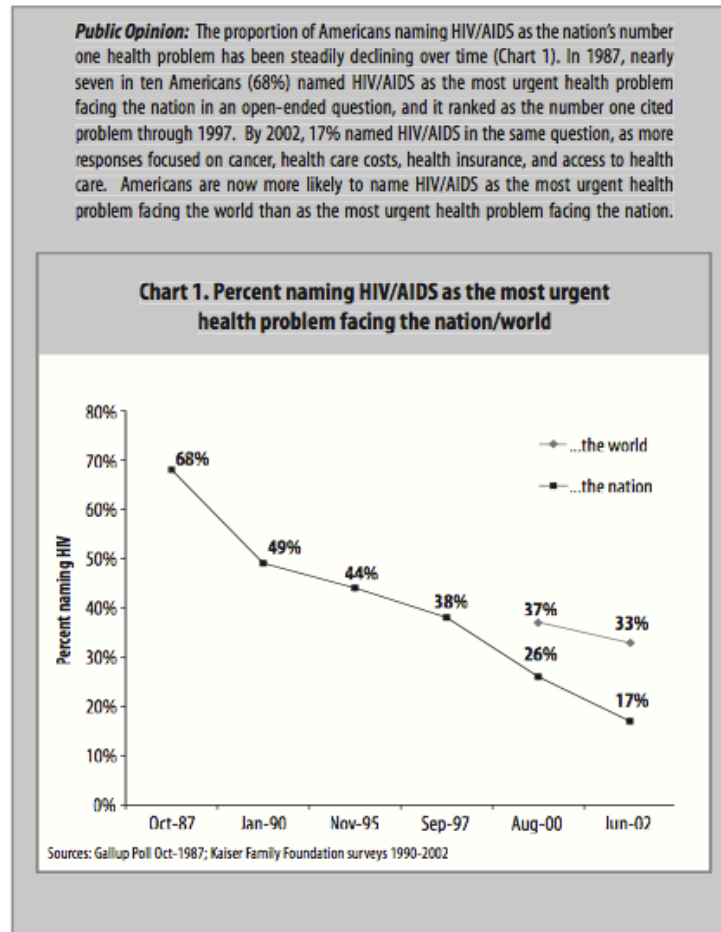
Many of my informants spoke about the fact that their sex education classes preached abstinence only, which is not at all effective in preventing sexually transmitted diseases such as HIV. I know that when I took sex education in high school, there was little to no mention of HIV/AIDS. I do remember, however, learning about the Ebola virus in my seventh grade science class. I vividly remember this video because there was a patient who was bleeding out of her eyes; this graphic visual stuck with me because it was so disturbing. I think that sex education classes should start at a younger age, around middle school years, when children are becoming adolescents and beginning puberty. Furthermore, I think that using scare tactics would be helpful in preventing HIV/AIDS. In my Global AIDS Epidemic class we have watched several videos of HIV-infected people, and seeing these people on their deathbeds has definitely increased my fear of the virus. Moreover, in a biology class I took about AIDS last winter, we learned about the side effects of the antiretroviral drugs, which include liver damage, seizures, and lactic acidosis, a buildup of acid in the blood. Information about these drugs should also be taught in conjunction with candid information about HIV. While it may be a radical step, exposing youth to images of HIV-infected people would be effective. One of my informants



said, “you don’t realize it’s real until you see someone who has it,” which I completely agree with. I have no doubt that if you see video footage of somebody dying of AIDS-related complications and learn about the detrimental side effects of treatment, you will be more likely to take preventative measures against HIV infection.

The HIV/AIDS epidemic, now in its 31<sup>st</sup> year in the United States, has ravaged communities and disproportionately affected marginalized populations. A multi-level approach encompassing policy-, community-, and individual-level interventions, needs to be taken in order to prevent new infections. I have outlined my thoughts in the previous sections about the course of action to end the American HIV/AIDS epidemic. I realize that it will not happen overnight, but I do believe that if the aforementioned changes happen, the end of the epidemic is possible.

## Appendix



[From *Kaiser Family Foundation Health Poll Report* survey, conducted on October 3-4, 2003 in AIDS at 21: Media Coverage of the HIV Epidemic 1981-2002 by Mollyann Brodie, Elizabeth Hamel, Lee Ann Brady, Jennifer Kates, Drew E. Altman].

Although this chart is ten years old, the message is still important. Americans do not see HIV/AIDS as being a crisis in the country, giving them a false sense of security and a feeling of invincibility to the epidemic.

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