Social Discrimination and Health

THE CASE OF LATINO GAY MEN AND HIV RISK

by Rafael M. Díaz
and George Ayala

the Policy Institute *of the* National Gay and Lesbian Task Force

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Preface

BY JUAN CARLOS VELAZQUEZ, LLEGO*

> *Crusando la frontera con un compañero de la conferencia de LLEGÓ fue muy facil. Estabamos muy contentos hablando de la vida loca en la frontera cuando me recorde de algo muy importante. "No debemos cruzar la frontera con un carro aquilado en los Estados Unidos," le dije a mí compañero.*

Crossing the border was easy with my colleague from the LLEGÓ Conference. We were happily talking about "la vida loca" when suddenly I remembered something quite important. "We should not cross the border with a rented vehicle," I told my colleague.

I have never seen anyone become so nervous in my life. I felt as though I had read his execution order to tell him that we probably should go back to the US given the fact that we cannot take rented vehicles to Mexico.

"*Mierda, es el carro de mi jefe*," ("Shit, this is my boss's car") replied my Puerto Rican friend. He made the sign of the cross, blessing himself and pleading "*María Madre de Dios ayudanos*" ("Mary Mother of God help us"). I tried to comfort him as I coached him how to give direct answers to questions once we talked to the immigration official.

"Where were you born?" barked the official.

"Puerto Rico," responded my friend.

"Of which country are you a citizen?" asked the official.

"I am Puerto Rican," answered my friend.

"Of which country are you a citizen?" insisted the official.

"Puerto Rico," he reiterated nervously.

"Tell him you are an American," I whispered to him.

"Pull over!" the official demanded as if we were guilty of a villainous crime.

*Lationo/a LGBT Organization

The border official checked the car's trunk and my friend's license. He let us pass without taking the time to thank us. We should have thanked him for not asking for the car's registration.

This exchange reminded me of the fact that I have many liberties and privileges being able to cross the border between Tijuana, Mexico and San Ysidro, California without too much concern. This is in dark contrast to the many who risk their lives trying to cross to a better life in the US. I use the word "better" loosely in this context, knowing well that too many Latinos in this country face the hardships of poverty, illiteracy, and discrimination.

We live in a world full of borders, divisions, and diverse realities. That is a given. These borders take shape for Latino gay and bisexual men in various ways that impact the efficacy of HIV/AIDS prevention interventions. The monumental work of Rafael Díaz and George Ayala demonstrates this point well as they point to the manner in which gay and bisexual men define themselves and their relative risk of HIV transmission. As researchers they operationalize the borders that exist in the lives of gay and bisexual Latino men.

The borders are developed through a socialization process or a social context that is embedded in racism, sexism, homophobia, and classism. It is imperative for this set of assumptions or realities to be considered as HIV prevention programs are developed with a supposed sense of cultural competency.

As we define cultural competency, we must ask whose culture are we addressing in regards to HIV/AIDS prevention. For too long competency for prevention programs was based on their effectiveness for gay white men. The realities of Latina/o lesbian, gay, bisexual and transgender (LGBT) populations were often discounted, ignored or misunderstood. We must constantly ask ourselves if competency is defined by a standard of privilege that includes a white, urban-centered, middle class, and English-speaking set of realities.

The health disparities that exist in this country afflict the black, the poor, the illiterate, the Latino, and the queer. The disparities act as borders. These divisions are real and create a reality for disenfranchised communities. I lived this lesson with my queer *hermanos* and *hermanas* (brothers and sisters) in my borderless travels between the US and Mexico at the 1999 LLEGÓ conference in San Diego and Tijuana. The lesson learned is not so different from that of my Puerto Rican friend who learned to grin and say, "I am an American," in crossing a border that made him feel so uneasy.

HIV/AIDS prevention services must be developed within a framework that considers the intersections of class, gender, race, and sexual orientation, as opposed to having them operate as distinct realities. For example, a working class gay Mexican man may have more in common with a Native American farm worker than a highly assimilated English speaking bisexual Cuban. The social structures surrounding gay and bisexual Latino male populations must be considered in the development of prevention strategies and a service delivery system that address the needs of Latino-serving community-based organizations, health departments, and AIDS service organizations. It is with this understanding that *Nuestras Voces* was developed. Díaz and Ayala recognize the borders that keep gay and bisexual Latino men closeted, oppressed, and at risk for HIV infection.

Border patrols exist for gay and bisexual Latino men in the form of critical parents, school bullies, and religious zealots who perpetrate homophobic conditions. Border patrols exist in the form of proponents of English-only laws, INS officials, and police precincts that attempt to keep gay and bisexual men from full participation in our society. These border patrols slowly chip away at the self-regard that Latino gay and bisexual men have for themselves and for one another. The link between self-esteem and risk taking behavior is well documented in the research of Díaz and Ayala. Let us hope that their research will help health professionals as much as school teachers and familia members to challenge border patrols in the form of oppressive racism, sexism, classism, and homophobia.

Undoubtedly, Díaz and Ayala have become my heroes for challenging assumptions about HIV prevention and for highlighting the impact of bias against queer Latinos.

Executive Summary

Disease prevalence and health outcomes are shaped by factors of social inequality. Preventable diseases and deaths are far more common among the poor and the disenfranchised. Though this finding is true at the local, national and global levels, little is known about the specific social forces, contexts and situations that impact specific health outcomes, and even less is known about the mechanisms or pathways by which oppression and discrimination impact individual health-related behavior.

In this study, based on empirical data from Latino gay and bisexual men in three US cities, we document the relationship of specific forms of social discrimination—homophobia, racism and financial hardship—to a specific health outcome: the increased risk for HIV transmission. A major obstacle in understanding the impact of social discrimination on health is that most public health models of preventable diseases—as well as the majority of publicly funded prevention programs and practices—continue to locate the source of health risk within the realm of individual behavior. In the case of the sexual transmission of HIV, for example, risk behavior is seen to result from deficits in individuals' level of information and knowledge, in their misguided assessments of risk, in their low perceptions of personal vulnerability, or in their ultimate lack of motivation or lack of personal intention to practice safer sex. Our data, however, challenge such individual models of risk by locating "risk" within the social contexts of groups and communities whose disease vulnerability is intrinsically linked to a history of sexual and racial discrimination as well as financial hardship.

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Between October 1998 and March 1999, as part of a multi-site study of Latino gay men in the US (named "Nuestras Voces/Our Voices"; R. Díaz, Principal Investigator and G. Ayala, Project Director), a probability sample of 912 Latino gay men was drawn from men entering social venues (bars, clubs and weeknight events identified as Latino and gay) in the cities of New York (n=309), Miami (n=302) and Los Angeles (n=301). The

three cities were chosen because of their identification with the three largest Latino ethnic/nationality subgroups in the US: Mexicans in Los Angeles, Puerto Ricans in New York, and Cubans in Miami. The quantitative survey was preceded by a qualitative study (conducted between November 1996 and March 1997), where we interviewed approximately 300 Latino gay men in the context of 26 focus groups in the three cities. The transcribed focus group discussions were used to create items for the quantitative survey, with the concern that survey items should reflect as closely as possible the lived subjective experiences (the voices!) of men who experience multiple sources of discrimination and struggle with the practice of safer sex in their lives. The study, funded by the National Institutes of Health (NIH), was designed to document the role of sociocultural factors—experiences of homophobia, poverty, and racism, among others—in determining or predicting the levels of sexual risk behavior observed in this population. Latino gay men in the three sampled cities reported widespread experiences of oppression and social discrimination, starting in their childhood. For example, 64 percent were verbally insulted as children for being gay or effeminate; 31 percent reported experiences of racism in the form of verbal harassment as children and 35 percent reported having been treated rudely as adults on account of their race or ethnicity; 61 percent ran out of money for basic necessities and 54 percent had to borrow money to get by during the last 12 months before the interview. The survey clearly demonstrated that experiences of social discrimination on the basis of race, class and sexual orientation are frequent and widespread among Latino gay men in the US.

Latino gay men reported widespread experiences of oppression and social discrimination, starting in their childhood.

The relationship between social discrimination and the risk for HIV was assessed by examining the differential occurrences of experiences of oppression in groups of men who differ in their reported levels of risk behavior. We assumed that men who reported unprotected anal intercourse with a non-monogamous recent partner (the "high-risk" group) would show higher rates of experiences of oppression, when compared to men who did not report such behavior (the "low-risk" group).

As predicted, men in the "high-risk" group reported more experiences of homophobia, racism and poverty than their "low-risk" counterparts. For example, more men in the high-risk group reported experiences of homophobia in childhood, in the form of verbal abuse (73 to 62 percent), physical abuse (31 to 15 percent), and feelings that their homosexuality hurt and embarrassed their families (79 to 68 percent). Men in the high-risk group also reported more experiences of racism in both childhood and adulthood, such as the experience of rude mistreatment (49 to 32 percent) and police harassment (34 to19 percent) due to race, ethnicity, or skin color. As hypothesized, men in the high-risk group reported more instances of financial hardship in the form of running out of money for basic necessities (54 to 39 percent) and having to look for work (29 to19 percent) more than two times in the last year. All these differences are statistically significant, and document the unequivocal relationship between experiences of social discrimination and sexual risk among Latino gay men. Above all, the findings suggest that oppression is not a thing of the past, but rather that poverty, racism and homophobia are experienced in the very close and immediate present, as demonstrated in our data regarding discrimination in adulthood.

Men in the "high-risk" group reported more experiences of homophobia, racism and poverty than their "low-risk"counterparts.

Nuestras Voces also found a number of resiliency factors correlated with higher self-esteem and lower psychological distress, and lesser likelihood to find oneself in high-risk situations that could lead to risky sexual behaviors. Among the most important resiliency factors surveyed were family acceptance and the presence of a gay role model while growing up. These finding have policy implications not only for tolerance curricula in the schools, but also for foster care for gay, lesbian, bisexual and transgender (GLBT) youth, and for the Boy Scouts controversy.

HIV prevention must include strategies to counter racism, poverty, sexism, homophobia, and AIDS stigma in full awareness that reducing their impact on individuals will most likely result in a dramatic reduction of HIV incidence.

Race, class and experiences of homophobia powerfully shape and organize sexual activity and sexual risk in the lives of Latino gay men. This finding has profound implications for the next generation of HIV prevention approaches for Latino gay men, as well as for other gay men of color and for all those who are at disproportionate risk for HIV infection. Specifically, HIV prevention programs should not focus simply on changing individual behavior, but on changing the social contexts where sexual risk occurs, with particular attention to those contexts of risk that are shaped by social oppression and discrimination. HIV prevention must include strategies to counter racism, poverty, sexism, homophobia, and AIDS stigma in full awareness that reducing their impact on individuals will most likely result in a dramatic reduction of HIV incidence. Organizing members of affected groups to increase community involvement and activism against the oppressive forces that shape the HIV epidemic might be the most efficient tool to counteract the hopelessness and fatalism that oppression breeds.

Focusing simplistically on condom use, or on a promising vaccine, or on rapid access to antiviral treatment shortly after exposure—while disregarding the social forces that limit individuals' ability to protect themselves—amounts to treating only the symptom. It would be poor prevention work and poor medical practice. If we are to be effective in our fight against AIDS and any other public health tragedies that feed on human powerlessness, HIV prevention workers and advocates must also be agents of social and cultural change.

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Disease emergence is a socially produced phenomenon…. Critical perspectives on emerging infections must ask how large-scale social forces come to have their effects on unequally positioned individuals.

Paul Farmer, *Infections and Inequalities*, 1999, p. 5.

Introduction

The observation that health and disease are deeply impacted and shaped by oppressive social factors is not new. Those who study morbidity and mortality in a wide range of diseases—from mental illness to infectious diseases—have long witnessed epidemiological profiles that connect disease prevalence and health outcomes with factors of social inequality.[1] Preventable diseases and deaths are far more common among the poor and disenfranchised—locally, nationally and globally. However, little is known about the *specific* social forces, contexts and situations that impact *specific* health outcomes, and much less about the mechanisms or pathways by which social and structural factors of oppression and discrimination impact individual health-related behavior.[2]

Our lack of knowledge is due in part to the fact that the relation between social inequality and disease has been mostly *inferred* from differences in health outcomes between groups who are differentially oppressed (e.g., the observation that significant health disparities exist between African American and white populations in the US). Rarely have studies measured and examined specific factors of discrimination (e.g., experiences of racism, homophobia, or financial hardship) as they impact the health, behavior and risk of individuals *within* the most affected groups. Such analysis within specific groups affected by social discrimination and oppression could illuminate both the specific lived experiences and the specific mechanisms by which oppression affects individuals within those groups.

In this study, based on empirical data from Latino gay and bisexual men in three US cities, we document the relationship of specific forms of social discrimination to a specific health outcome: the increased risk for HIV transmission. Using Latino gay men and HIV as an illustrative case can shed light on how social discrimination might produce the many physical and mental health issues facing gay, lesbian, bisexual and transgender (GLBT) communities in our nation, in particular within communities of color. It is our hope that *Social Discrimination and Health* will illustrate how and why social forces of oppression and discrimination can produce negative health outcomes, thereby shedding light on the situation of other affected groups and communities.

The Social Shape of the AIDS Epidemic

One of the most clear and consistent findings of research on the AIDS epidemic is that HIV infection is not randomly distributed in the population. Rather, the epidemic is shaped by and located within the boundaries of oppressive social forces—poverty, racism, homophobia and gender inequality—that seriously limit the ability of individuals, groups and communities to protect themselves against this devastating disease. In the US, African Americans and Latinos are now eight and three times more likely, respectively, than non-Latino whites to be diagnosed with AIDS.[3] This finding witnesses not the virus's preference for a particular skin color, but the fact that in the US ethnicity correlates with economic hardship and racial discrimination.

HIV is spreading not at random, but within pockets of powerlessness and alienation created by social injustice, inequality and oppression.

Among gay and bisexual men, one of the groups most impacted by HIV in the US, the HIV epidemic is becoming an epidemic of mostly ethnic minority men. In 1998, for the first time in the epidemic, the majority of new AIDS cases among men who have sex with men (MSM) were diagnosed in ethnic minority men.[4] For the year 1999-2000, the Centers for Disease Control and Prevention (CDC) reported that 69 percent of new HIV infections were among African American and Latino individuals, most of them men who have sex with men. In the most recent (1994-1998) and comprehensive study of adolescent and young MSM in the US, Valleroy et al.[5] found that HIV infection rates were much higher among both African American and Latino men. This trend attests to the compounding negative effects of multiple sources of discrimination. It is increasingly clear that HIV is spreading not at random, but within pockets of powerlessness and alienation created by social injustice, inequality and oppression.

Challenging Individual Models of Health and Prevention

Even though epidemiological data clearly connect disease outcomes to factors of social oppression, public health models of preventable diseases—as well as the majority of publicly funded prevention programs and practices—continue to locate the source of health risk within the realm of individual behavior. In the case of the sexual transmission of HIV, for example, risk behavior is seen to result from deficits in individuals' level of information and knowledge, in their misguided assessments of risk, in their low perceptions of personal vulnerability, or in their ultimate lack of motivation or lack of personal intention to practice safer sex. Most HIV prevention practices to date can be understood as well-intentioned attempts to infuse individuals with the necessary levels of information, motivation and personal skills to practice safer sex. Such programs assume that as long as individuals are adequately armed with the appropriate tools—psychological and latex—for personal prevention, the practice of safer sex can be guaranteed across all contexts, situations or social circumstances.

In part, the location of HIV risk within the individual is based on the factual recognition that HIV is transmitted through a particular set of behavioral practices involving the exchange of bodily fluids, as in the case of unprotected sexual intercourse or the sharing of intravenous needles. On the other hand, the powerful hegemonic ideology that HIV risk is a matter of individual behavior and individual responsibility is also fueled by a strongly rooted national ethos where, as an article of indisputable faith, America is conceived as the land of equal opportunity for all. Thus, if anyone, or any group, is differentially affected or impacted by a problem or disease, there must be something wrong with "them," since the social context is assumed as facilitative and rich with opportunities for growth and wellness for all. It is no surprise that deficit models and individual pathologizing of social problems—from school dropout rates to HIV infection—blossom so well in America.

In an epoch-marking meeting of social and behavioral theorists convened by the National Institute of Mental Health to develop a theory of HIV risk and prevention, the experts concluded that

> AIDS is first and foremost a consequence of behavior. *It is not who you are but what you do* that determine(s) whether or not you expose yourself to HIV, the virus that causes AIDS.[6]

While the theorists were justly reacting against the commonly held notion of "risk group" membership (i.e., homosexuals, drug users, Haitians, etc.), so prevalent in the early years of the AIDS epidemic in the US, they failed to note that "who you are"—not in terms of individual identity, but in terms of social location within a grid of oppressive factors—determines to a great extent what you can and cannot do. In other words, individual intentionality may indeed predict individual behavior, but only in contexts and situations where individuals are powerful and can exercise their personal agency without the constraints of power inequalities based on gender, class and/or race, to name a few. This is precisely the most important message conveyed by the social shape of the epidemic: HIV is being transmitted precisely in those contexts and circumstances created by social discrimination and oppression, where individuals are not able to exercise power and control, or self-determine at will their own behavior. Those contexts, as will be shown below in the case of Latino gay men, are typically shaped by situations of inequality and discrimination, where survival needs override the need for health-promoting behavior, and where a sense of deep hopelessness about the inevitability of HIV infection is shaped by constant and repeated experiences of powerlessness over many other adverse life circumstances, such as chronic financial hardships, unstable and unsafe housing, or the constant threat of street violence and police brutality.

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HIV/AIDS in Latino Men who Have Sex With Men

EPIDEMIOLOGICAL PROFILE

The social and sexual lives of many Latino gay and bisexual men have been impacted by at least three social oppressive forces—poverty, racism and homophobia—that, acting in an unfortunate synchrony, tend to produce devastating experiences of social alienation and personal shame. Although many men have responded to the oppression with creative acts of personal agency, ranging from committed social activism to acts of personal heroism, others have been deeply troubled and debilitated by financial hardship, family rejection and discriminatory practices that prevent their fair participation in professional life and in the gay community. Thus, in light of the observed relations between social inequality and health outcomes, it is not surprising that Latino gay men constitute one of the most vulnerable groups in the nation for the transmission of HIV.

HIV seroprevalence: The percentage of individuals who are HIV-infected in a given population.

HIV seroconversion: The percentage of individuals who become HIV-infected in a given time period.

Latino gay/bisexual men show some of the highest rates of HIV seroprevalence, seroconversion, and unprotected anal intercourse with multiple partners.[7] By June 1999, a total of 51,681 AIDS cases had been diagnosed among Hispanic/Latino men who have sex with men (MSM); Latino MSM thus constitute about one half (49 percent) of all reported Latino male AIDS cases in the nation.[8] However, CDC statistics on "exposure category" among Latinos in the US should be seen as conservative estimates of MSM cases. About one fourth (22 percent) of all US Latino AIDS cases diagnosed in 1998-1999 did not report risk exposure category;[9] most likely, a large proportion of those undetermined cases occurred among MSM, but were not reported as such due to severe stigmatization of homosexuality in the Latino culture.[10] Percentages of Latino AIDS cases accounted for by MSM vary substantially across the three major ethnic subgroups. In 1992, for example, 70 percent of Cubans, 59 percent of Mexican, and 18 percent of Puerto Rican AIDS cases were among MSM.[11] The relatively low percentage of MSM among Puerto Rican AIDS cases reflects the higher incidence of HIV transmission through injection drug use in this population. However, there are numerous indications that many Puerto Rican injection drug users also engage in same sex behavior, but stigmatization of

homosexuality among both drug users and their service providers prevents accurate reporting of sexual activity.

Because we lack a systematic plan for reporting and counting new HIV infections in the nation, estimates of HIV seroprevalence are difficult to obtain for Latino gay and bisexual men, as well as for any other particular group in the nation. However, new sampling strategies now make it possible to estimate HIV prevalence in different populations at risk. Probability sampling permits us to recruit a representative sample of research participants for a given population. Also, because the actual probability of being selected into a study is directly measured, this method allows for data collected to be weighted or corrected to estimate the true prevalence of a given variable within a measurable margin of error. Fortunately, we have by now two large studies that involve probability samples of Latino gay and bisexual men and include self reported data on HIV testing and HIV infection.

In a recent household probability sample (Urban Men's Health Study; n=2,881) of geographic areas with high concentration of MSM in four different US cities (San Francisco, Los Angeles, Chicago and New York), a substantial number of Latinos (n= 246, or 10 percent of the sample) were included. In this study, 19 percent of the Latino sample reported an HIV-positive status. A second study, a probability sample (Nuestras Voces; n=912) of Latino gay/bisexual men who attend Latino gay venues in the cities of Los Angeles, Miami and New York, yielded a somewhat similar, though slightly higher prevalence of 22 percent. From these two studies, and taking into account the limitations of self-reporting a stigmatized status, it can be said with great confidence and conservatively that about one out of five Latino gay and bisexual men in large US urban centers are infected with HIV, a sad and sobering finding.

Rates of sexual risk behavior among Latino gay men are disproportionately high. In five different studies of gay and bisexual men in the US, Latinos have reported the highest rates of unprotected anal intercourse, even when compared to men from other ethnic minority groups. In San Francisco, where research in the late 1980s and early 1990s documented significant reductions in risky sexual behavior among gay and bisexual men, rates of unprotected anal intercourse among Latino men have remained relatively high. In a survey of knowledge, attitudes and behavior conducted in the summer of 1990 in San Francisco's American Indian, Filipino and Latino gay and bisexual male communities, 35 percent of Latinos reported unprotected anal intercourse during the last 30 days, as compared to 25 percent of Filipinos and 12 percent of American Indians. In a more recent study of young gay men in the San Francisco Bay Area, 40 percent of Latinos reported unprotected anal intercourse during the last six months, as compared to 38 percent of African Americans and 28 percent of non-Latino whites.

In the Nuestras Voces study rates of unprotected anal intercourse were 28 percent (estimated by sexual activity in the last two months) and 37 percent (estimated by sexual activity with the last two sexual partners within a 12 month period). However, the data from the last two partners suggest that only about half of the 37 percent of men who report unprotected anal intercourse (or 18 percent of the sample) do so with a non-monogamous partner. Thus, it must be noted that a large majority of Latino gay men are genuinely attempting to be safe in their sexual activity, by either condom use and/or monogamy practices. Interestingly, the more recent data on rates of recent risk behavior (UAI with non-monogamous partners) and data on HIV prevalence are both estimated at about 20 percent.

Nuestras Voces

THE NATIONAL STUDY OF LATINO GAY MEN

Between October 1998 and March 1999, as part of a multi-site study of Latino gay men in the US, a probability sample of 912 Latino gay men was drawn from men entering social venues (bars, clubs and weeknight events identified as Latino and gay) in the cities of New York (n=309), Miami (n=302) and Los Angeles (n=301). See the Appendix for a description of the probability sampling and recruitment procedures.

The quantitative survey was preceded by a qualitative study, conducted between November 1996 and March 1997, in which we interviewed approximately 300 Latino gay men in the context of 26 focus groups in the three cities. The transcribed focus group discussions were used to inform the quantitative survey, with the concern that survey items should reflect as closely as possible the lived subjective experiences (the voices!) of men who experience multiple sources of discrimination, and struggle with the practice of safer sex in their lives. Between 1997 and 1998, 18 months were devoted to an analysis of the qualitative data and to the construction and pilot testing of the questionnaire to ensure its sensitivity, appropriateness and psychometric quality—that is, the ability of the survey to reliably measure important constructs in the study (e.g., poverty, homophobia, social alienation, etc.) through multi-item scales.

The study, funded by the National Institutes of Health (NIH), was designed to document the role of sociocultural factors—experiences of homophobia, poverty, and racism, among others—in determining or predicting the levels of sexual risk behavior observed in this population. The study collected detailed information on three important outcomes: unprotected anal sex, substance use, and symptoms of psychological distress. The study also gathered other data relevant to HIV prevention, such as men's participation in different contexts of sexual risk and socially shared meanings of condoms and condom use. More importantly, the study was the first attempt to measure directly men's experiences of homophobia, poverty and racism, in an attempt to document the role of specific sociocultural oppressive factors in reported individual sexual risk behavior. The rich database is currently under analysis, and we will present below only some preliminary findings regarding the relation between social oppression and the risk for HIV.

Analysis of the weighted data yielded the following demographic profile: (84 percent) self-identified as gay or homosexual, 15 percent identified as bisexual, and the remaining one percent identified themselves with a wide variety of non-heterosexual labels such as "queer," "pansexual," or "*joto*" (faggot). Measures of acculturation (an index of integration and participation in mainstream English-speaking culture), based on language use and length of residence in the US, show that the sample falls mostly on the lower end of the acculturation scale. The majority (72 percent) of respondents were immigrants, with 53 percent of immigrants having been in the US 10 years or less, and over one-third reporting mostly speaking Spanish with peers. Thus, as originally intended by recruitment in Latino-identified gay bars, we were successful in obtaining a sample that self-identifies as homosexual or gay but remains close to the Latino community and culture. Unlike the highly acculturated gay Latinos that are typically recruited in mainstream gay venues, this sample can give us the perspective of homosexual men who also suffer the social and economic marginalization of ethnic minority groups in the US. Even though this was a relatively young (87 percent between 20-40 years of age) and highly educated group of men (64 percent reported some college or more), 27 percent of the sample was unemployed at the time of the study.

The Experience of Triple Oppression

The focus group transcripts made obvious that the lives of Latino gay men—their familial, social, and sexual lives—have unfolded within a grid of oppressive social forces that deeply impact their sense of self, their relationships, and their social and professional opportunities. The qualitative data yielded a wealth of information regarding men's experiences of homophobia, racism and financial hardship, documented in the following paragraphs and quotes.

HOMOPHOBIA

Men told us about experiencing both verbal and physical abuse, police harassment and decreased economic opportunities on account of their being gay and/or "effeminate." They told us about powerful messages—both explicit and covert—in their communities, telling them that their homosexuality made them "not normal" nor truly men; that they would grow up alone without children or families; and that ultimately their homosexuality is dirty, sinful and shameful to their families and loved ones.

> I was a devout Catholic, hated gay people, and was married twice, and actually put two women through a lot because I couldn't accept myself. I came out when I was 30 and it was very difficult for me to deal with being gay. I tried to commit suicide…. And when I had the strength to say, "Well, this is who I am," my family didn't speak to me for over 15 years….

Men told us about having to opt for exile and migration in order to live their homosexuality away from their loved ones, whom they worried they would hurt if they opted to live openly their homosexual desires. And many others told us about having to live double lives and pretend to be straight in order to maintain social connections and employment opportunities.

RACISM

Similarly, men reported multiple instances of discrimination, verbal and physical violence, police harassment, and decreased sexual and social opportunities on account of their being Latino, immigrant, and/or of a darker skin color. A great deal of racism was experienced in the gay community and at gay venues, where men reported not feeling at ease, not feeling welcomed, and some even reported being "escorted out" of venues on account of their different looks, color, or accent. Some men felt sexually objectified by white boyfriends and lovers, who stereotypically paid more attention to their skin color or Spanish accents than to their true selves. These men felt invisible, that they were just being used as fantasy material, rather than being a part of a more authentic and equitable relationship. Many others encountered overt racist rejection in the context of sexual and lover relations.

> My first lover was white, and his white friends were on his case about why is he living with a Puerto Rican lover…. The fact is that they can fuck with Puerto Ricans, but not have one as a lover. They had a big problem with that because, you know, I'm just Puerto Rican, why is he with me?

POVERTY

Many men reported experiencing poverty both while growing up and in the present. Men talked about difficulties meeting their day-to-day living expenses and often struggled with inconsistent employment and sources of income. Many reported not having health insurance nor access to decent health care. Others reported they did not have their own place to live, and had to rely on friends or relatives for temporary housing.

Anger surfaced when remembering the poor conditions of their families of origin, in the face of obvious social inequality:

> In my home it was pretty much hand-to-mouth, and later on I began to realize that a lot of what we considered luxuries was commonplace with these other folks, and they didn't live but maybe two blocks down the street from me. It made me probably just a little sad, I guess. I don't think anger came into it yet, because I didn't have an analysis of the economic situation.

Others had to face the harsh reality of extreme poverty and misery in the inner city, with a deep sense of lack of control and unsettled resignation. Here's a voice from the South Bronx, one of the poorest and most devastated areas in the country, which, though ostensibly about the poverty of the neighborhood, could also describe feelings about and the inevitability of HIV infection:

> I have this impending doom.... Like the world is going to come to an end, we're going to die…. A lot of my friends as well, being poor, living in the South Bronx, they say "fuck it." It's going to be like this…that's the way life is….

Measuring Oppression

Our research team painstakingly converted the focus group narratives into a survey instrument that would reliably measure men's experiences of oppression in their lives, from childhood to adulthood. A quantitative survey in a probability sample of Latino gay men was extremely important. While the qualitative focus group data informed us with richness and depth about men's experiences of discrimination and oppression, only the quantitative data could give us the true dimensions of the problem, namely, how many men actually had those experiences. The quantitative data could then be used to ask the HIV-related question: "Are those experiences truly related to or predictive of sexual risk?" By measuring actual experiences of specific forms of oppression among individual members of an oppressed group—in this case Latino gay men—and by examining the link between those experiences and sexual risk behavior, we were addressing the gaps in current research, as outlined by both Paul Farmer and Nancy Krieger,[17] two of the most outspoken experts on issues of social inequality and health.

Our ambitious goal was that, as much as possible, every item in our survey questionnaire would be taken verbatim from the voices of the men, as transcribed from the focus groups. We set this goal in full awareness that HIV research, in order to be maximally useful, must reflect the actual experiences and struggles of those we intend to serve. We came close to our goal, creating reliable scales that measured experiences of *homophobia* (sample questions: As you were growing up, how often did you feel that your homosexuality hurt and embarrassed your family? As an adult, how often have you had to pretend that you are straight in order to be accepted?); experiences of *racism* (How often have you been turned down for a job because of your race or ethnicity? In sexual relationships, how often do you find that men pay more attention to your race or ethnicity than to who you are as a person?); and experiences of *poverty* or financial hardship (In the last 12 months, how often did you run out of money for your basic necessities? In the last 12 months, how often have you had to borrow money from a friend or a relative to get by financially?).

Table 1: Experiences of Oppression

Percentage answering in the affirmative

Homophobia:	
verbally harassed in childhood for being gay/effeminate	64%
felt that homosexuality hurt/embarrassed family	70%
had to pretend to be straight in order to be accepted	64%
heard as a child that gays would grow old alone	71%
had to move away from family because of homosexuality	29%
harrassed by police because of homosexuality	20%
Racism:	
verbally harassed in childhood because of ethnicity	31%
treated rudely as adult because of ethnicity	35%
experienced discomfort in white gay spaces due to ethnicity	26%
harassed by police because of ethnicity	22%
sexually objectified because of ethnicity	62%
Poverty:	
within past year, ran out of money for basic necessities	61%
within past year, had to borrow money to get by	54%
within past year, had to look for work	45%

Latino gay men in the three sampled cities reported widespread experiences of oppression and social discrimination, starting in their childhood (Table 1).

The survey clearly demonstrated that experiences of social discrimination on the basis of race, class and sexual orientation are frequent and widespread among Latino gay men in their 20s and 30s. The main limitation was that a few months after the survey—in the context of follow-up in-depth interviews with survey participants—participants communicated their frustration in having to respond to such important questions in close-ended survey form. As it turned out, many items opened up important and painful memories, and men felt very frustrated not being able to tell the stories the items evoked. A second limitation is that our sample represents only the population of men who go to Latino gay venues, and not all Latino gay men. In particular, it leaves out Latino men who have sex with other men and do not identify as gay or bisexual; our inclusion criteria excluded persons who identified as heterosexual. However, for the purpose of clarity and expedience, we refer to our target population as Latino gay men.

Relation of Oppression to Sexual Risk

How do experiences of homophobic, racial and economic oppression relate to behaviors that can place people at risk for HIV/AIDS? We decided to assess this relation first by examining the differential prevalence of experiences of oppression in groups of men who differ in their reported levels of risk behavior. We hypothesized that men who reported unprotected anal intercourse with a non-monogamous recent partner (the "high-risk" group) would show higher rates of experiences of oppression when compared to men who did not report such behavior (the "low-risk" group).

As predicted, men in the "high-risk" group reported more experiences of homophobia, racism and poverty than their "low-risk" counterparts. For example, more men in the high-risk group reported experiences of homophobia in both childhood and adulthood. Men in the high-risk group also reported more experiences of racism in both childhood and adulthood. However, possibly because this is mostly an immigrant sample (73 percent), differences between high- and low-risk groups were stronger for racism experienced as adults (Table 2). All these group differences are statistically significant.

In order to study the relationship between poverty and sexual risk, we examined experiences of financial hardship in the last 12 months. In an attempt to assess "hardship" more accurately, for this analysis we analyzed the prevalence of the following events more than twice in the last 12 months: Running out of money for food and/or rent, having to borrow money for basic necessities, and having to look for work. Once again, as hypothesized, men in the high-risk group reported more instances of financial hardship (Table 2).

These findings document an unequivocal relationship between experiences of social discrimination and sexual risk among Latino gay men. Above all, the findings suggest that oppression is not a thing of the past, but rather that poverty, racism and homophobia are experienced in the very close and immediate present, as demonstrated in our data regarding discrimination in adulthood. Race, class and experiences of homophobia powerfully shape and organize sexual activity and sexual risk in the lives of Latino gay men.

Table 2: Relation of Oppression to Sexual Risk

Percentage answering in the affirmative, by risk group

Homophobia, childhood:	
verbal abuse because of homosexuality	62% / 73%
physical abuse because of homosexuality	15% / 31%
felt that homosexuality hurt/embarrassed family	68% / 79%
Homophobia, adulthood:	
verbal abuse because of homosexuality	45% / 67%
physical abuse because of homosexuality	7% / 16%
police harassment because of homosexuality	17% / 34%
Racism, adulthood:	
treated rudely because of ethnicity	32% / 49%
harrassed by police because of ethnicity	19% / 34%
sexually objectified because of ethnicity	58% / 75%
Poverty:	
within past year, ran out of money for basic necessities	39% / 54%
within past year, had to borrow money to get by*	27% / 32%
within past year, had to look for work	19% / 29%

*difference not statistically significant

Explaining the Link Between Oppression and Sexual Risk

The finding that groups who differ in levels of sexual risk also differ in their reported experiences of social discrimination, though extremely important, does not tell the whole story. As Farmer and Krieger[18] have suggested, there is a crucial need to understand the mechanisms—the "how and why"—through which experiences of discrimination and oppression impact individual health factors—in our case, the risk for HIV transmission. The qualitative and quantitative data from the Nuestras Voces study are rich with information that could explain the relationship between oppression and HIV risk. We have begun exploring those mechanisms through analyses of the focus group narratives, as well as through various statistical analyses of our quantitative survey data, including multiple and logistic regression and path analysis techniques—statistical techniques that permit us to explore possible causal relationships between social oppression and the risk for HIV transmission.

Our findings to date suggest that, in order to understand the relation between oppression and sexual risk behavior, we need to understand two types of intervening or mediating variables. First, we need to understand the psychosocial impact of oppression, that is, the impact of oppression on individuals' social/interpersonal relations, as well as on their psychological health and well-being. Second, we need to understand the role of oppression in creating specific contexts of sexual risk: situations in which it is difficult to negotiate safer sex, or contexts that compete with the enactment of safer sex intentions. In what follows, we elaborate with two examples from our qualitative data.

EXAMPLE 1: HOMOPHOBIA AND SUBSTANCE USE

Many men have experienced homophobia, early on in their lives, in the form of brutal messages, overt and covert, that homosexuality is dirty, sinful, and shameful. These messages are heard day in and day out, within families, in schools, and churches, at playgrounds, and in the media. Unfortunately, those messages do not go away when one

comes out, or migrates to another country, or moves to a more hospitable city where homosexuals congregate. In the absence of a true transformative process of liberation, grounded in actual experiences of both social- and self-acceptance and respect, the homophobic messages tend to remain at very deep levels of consciousness where they create a sense of anxiety, guilt, discomfort and conflict about same-sex desire:

> *…you also grow up being told that being gay, you're going to be punished for it. It's something dirty. And I guess being told that from when you are little, it's somewhere in the back of your head, that I'm going to be punished no matter what.*

It is not surprising that many of these men try to find comfort and relief from those painful memories (now internalized as inner voices, and deeply felt emotions) with the help of mind-altering substances:

> *I used drugs to kind of run away from the world because I didn't know how to live. I didn't know how to deal in a healthy manner with confrontations. I didn't know who I was…. Being gay, you know, I was never supported in anything. So I kind of, like, was scared and running away, and what drugs did for me was kind of keep me sane in a sense. It kept me—it was kind of like a comforter for me.*

In the words of another participant:

> *A lot of gay men go through a tremendous struggle, you know, coming out, coming to terms with yourself. You go through a … I know I went through a big process of hating myself and being happy with myself, and that still for a very long time when I was finally able to break through that, it was a lot. And that's why I say a lot of the drugs in the gay world has to do with that, coming out and all the pain that you have to go through, losing your family, losing your friends. And then dealing with AIDS on top of all that. And then, yeah, who's not going to turn to a bottle of liquor or some coke?*

Men spoke of substances—alcohol and drugs—as aids, comforters, and tools for survival.

Substances are used to cope not only with homophobic messages but also with the anger and frustration caused by poverty, racism and many other forms of social discrimination and abuse. The most striking aspect of our data was how men spoke of substances—alcohol and drugs—as aids, comforters, and tools for survival. Many saw substances as the only way to obtain some relief from very tough and demanding social situations, as well as from feelings of personal shame and anxiety around same sex sexual situations. Thus, it was no surprise that men also used substances to cope with sexual shame:

> *We do it [sex with men] because it's pleasurable, but then there's this big guilt trip that comes afterwards. It's like you do it, you feel guilty and then you don't do it for a while, then you do it again, you feel guilty again … I see a lot of men get drunk or get high in order to have sex, because they can't say—a lot of Latino men can't say, "I want to have sex because I want to enjoy sex with another man." So no, the excuse is "well, you know, I'm kind of drunk, I'm kind of high."*

In line with our qualitative findings, in our quantitative data some of the strongest predictors of unsafe sex (unprotected anal sex with non-monogamous partners) are frequency of heavy drinking, recent drug use, and participation in sexual situations under the influence of alcohol and/or drugs.

Returning to our basic question regarding the relation between oppression and HIV risk

behavior, we observe a clear pattern—an explanatory mechanism—with respect to substance use. Experiences of homophobia not only have a devastating impact on men's self-esteem and psychological well-being, but promote strategies of coping and escape through the use of substances. This behavioral pattern of substance use as a coping strategy—grounded not on personal pathology, but rather on the experience of social oppression—is then likely to be re-created in sexual situations that evoke discomfort and anxiety. Social oppression in the form of homophobia can be seen as directly promoting one of the most difficult contexts for the practice of safer sex—sex under the influence of substances.

EXAMPLE 2: POVERTY, HOPELESSNESS, AND CYCLES OF BROKEN SEXUAL ABSTINENCE

As the AIDS epidemic becomes more and more entrenched within the day-to-day landscape of urban poverty, HIV transmission is perceived as yet another factor that cannot be controlled in men's lives. HIV takes on the same sense of inevitability as other factors in the landscape—unemployment, homelessness, violence, police harassment, lack of access to health care, and multiple forms of economic and social hardships. As one of the interviews quoted earlier suggests, men who live in extreme poverty, as in the case of the South Bronx, have a deep "sense of doom" about life, a feeling that their world "is going to come to an end" at any time, because it is a world that conspires against the sense of personal agency and control.

"You can't avoid it, you know what I'm saying?… It's inevitable, I think this disease is inevitable…."

We've always been surprised by how high our samples of Latino gay men score on scales of HIV "perceived risk." It seems that, more than simply perceiving themselves at a given level of HIV risk, the high scores reveal the fact that many Latino gay men perceive themselves as unable to control risk. Many of them bring to sexual situations a sense of hopelessness, inevitability and fatalism about HIV infection—not merely expressed as a belief about personal inability to prevent HIV infection, but rather a reflection of contextual or systemic constraints. If many of these men can control so little in their worlds, why should they be able to control HIV?

> *And you get tired of running away from it and when you do something in practice, safe practice, you still feel scared. I feel scared. You can't avoid it, you know what I'm saying? Because one: I bite my lips a lot. Two: my cuticles are really dry. You know what I'm saying? When you are playing around with someone, I get scared, man. Even if I'm like jerking somebody off, like it comes in my hand. And I do a lot of things with my hands and I get cuts in my hands, so you get scared. And then you think about it, "Oh, shit, I got a cut today." And you start looking you got cut. It's inevitable, I think this disease is inevitable….*

Many men respond to their fears and sense of inevitability by practicing sexual abstinence.

> *When you mentioned the condom, it was just a reminder of what's out there, and so I tend to go toward abstinence. It got to that point because what's out there got to me, so now I'm turned off to sexuality….*

But sexual abstinence, as can be predicted for men who report strong sexual interest and desire, is a fragile and short-lived safer sex strategy:

> *That's really scary, because when I had unprotected sex it's been sometimes when I've been abstinent. Because you go through cycles, I'm really scared and I'm not doing anything at all and then all of a sudden, "boom," that one person shows up that's really appealing and seduces you, and the moment is right. All the abstinence you had backed up, it goes away. This is it. And then you go for it and afterwards you are like, "uh-oh, a relapse, I slipped…ok what do you do now?" Then the fear, and then you go run and you get tested and then you go through this again and again….*

Factors of Resiliency and Strength

Most AIDS prevention research is problem-oriented and deficit-focused. That is, it emphasizes individual vulnerability to HIV and implies that there is something weak, wrong or lacking in an individual's ability to guard against infection. Protective factors or factors that reinforce or strengthen psychological/emotional resiliency against HIV infection seldom receive the attention they need.

In our discussions with the members of our study's National Community Input Group and with other members of the community, we were urged to consider such factors in our study. The inclusion of a resiliency scale in the survey was aimed at showcasing the resiliency demonstrated by Latino gay men throughout the country, even in the face of the most adverse socioeconomic and personal situations. Our conversations with Latino gay men in Los Angeles, New York, and Miami were punctuated with personal stories of courage, strength, competency and resilience. Social discrimination didn't just happen to individuals. Individuals found ways of adapting to their life circumstances, of navigating the complexities of multiple, ever-shifting and sometimes competing value systems within and among the various social situations in which they found themselves, and of discovering new ways of surviving and/or moving on.

The resiliency scale included in the survey is based on conversations we had with both community members and service providers about the factors they viewed as protective against HIV infection. These factors can be divided into five domains: "outness" to family and peers (e.g., "Have you told your mother or female guardian that you're homosexual/bisexual?"), family acceptance (e.g., "Is there at least someone in your immediate family that you can talk openly with about your homosexuality/bisexuality?"), life satisfaction (e.g., "Are you satisfied with your sex life?"), social connectedness to referent group (e.g., "Are you involved with Latino gay organizations?"), and presence of a gay role model while growing up (e.g., "Growing up, were there older gay friends or relatives whom you looked up to or who served as role models for you?").

We recognize that resiliency in Latino gay men can by itself serve as the subject of many research projects. Although seriously limited in scope, the survey's resiliency scale is a

beginning and offers a very revealing glimpse of the role that these particular factors play in moderating the impact of social discrimination, thereby reducing the risk of HIV transmission.

Having immediate family members know about their homosexuality and securing their support for being gay was important to many of the men we interviewed. Overall, participants were more likely to have told their mothers than their fathers about their sexuality. The Latino gay and bisexual men interviewed reported feeling satisfied with their sex lives. However, when asked about their romantic/lover relationships the percentage drops more than 20 points. One third of participants reported involvement with a Latino gay group. This number is lowest in Miami, with only 25 percent of participants involved in Latino gay groups (Table 3).

Table 3: Resiliency Factors

Percentage answering in the affirmative

Outness:	
have told mother about being gay/bisexual	57%
have told father about being gay/bisexual	36%
feel accepted by mother	65%
feel accepted by father	41%
"out" to co-workers/peers	41%
can talk openly to at least one immediate family member	73%
General satisfaction:	
satisfactory sex life	86%
satisfactory romantic/lover relationship(s)	64%
involved with Latino gay group	33%

In hypothesizing about the role of resiliency in diminishing the risk for HIV transmission, we assumed that participants reporting high-risk sexual behavior would score lower on the resiliency scale than participants reporting less risky sexual behavior. However, in our analysis we found that resiliency factors by themselves did not directly influence sexual risk behavior. Resiliency did, however, influence "mediating" factors like self-esteem, level of psychological distress reported, social isolation, substance use and likely participation in high-risk situations. The more resilient the participant (as defined by the survey items described above), the higher his self-esteem, the lower his psychological distress, the lower his reported substance use, the lower his social isolation, and the less likely he reported finding himself in high-risk situations that could lead to risky sexual behaviors. Moreover, the influence that resiliency has on these mediating factors offsets the influence that social discrimination has on the same factors. Social discrimination results in poor self-esteem, higher psychological distress, and

other negatives. Resiliency factors, on the other hand, are related to increased self-esteem and alleviate social isolation, both important predictors of sexual risk .

There was another interesting observation related to resiliency factors and HIV seroprevalence. Overall, HIV seroprevalence was found to be high in this sample of Latino gay men, 22 percent. However, seroprevalence varied by city, from 7 percent in Miami to 17 percent in Los Angeles to 34 percent in New York City! When city comparisons were made, seroprevalence correlated negatively with family acceptance, outness, and reported satisfaction with romantic relationships. In other words, cities with higher numbers of HIV-positive individuals reported lower overall levels of family acceptance, outness and satisfaction with lover relationships. On the other hand, participants in cities with higher seroprevalence were also more likely to be involved with promoting gay rights and/or Latino rights and/or involved in Latino gay groups.

The Impact of AIDS and HIV Stigmatization on the Lives of Latino Gay Men

The extent of the impact (physical, psychological, and social) left behind by the AIDS epidemic can never fully be measured. It is critical, however, to document to the best of our ability the ways our lives have changed and continue to change as a result of this disease and our responses to it.

Latino gay men participating in our study spoke at length about the impact of AIDS on their lives. Their ability to trust other people, their ability to find and enjoy sex, and their ability to find and enjoy romantic/lover relationships have all changed as a result of the AIDS epidemic. Participants expressed great anxiety over their physical health and worried, when there was something physically wrong, that it might be AIDS. HIV-positive men were more likely to be worried that each time something was physically wrong with them it might be AIDS.

In focus group conversations, participants spoke about HIV infected individuals in highly negative terms.

The majority of participants (78 percent) reported that the AIDS epidemic made it more difficult to trust other people. When we compared the responses of HIV-positive respondents with HIV-negative individuals, we found that HIV-negative men were more likely to report difficulty trusting others than HIV-positive men (86 percent vs. 67 percent, respectively).

A large proportion of both HIV-positive (66 percent) and HIV-negative (70 percent) participants reported that the AIDS epidemic made it more difficult for them to enjoy sex. Half of all men (51 percent) reported that the AIDS epidemic made it more difficult to find lovers. More HIV-positive men (56 percent) found it difficult to find lovers than negative men (45 percent).

One of the most striking and unexpected findings of our study was the high prevalence of stigma related to HIV in all three cities. In focus group conversations, participants spoke about HIV-infected individuals in highly negative terms. HIV-positive individuals were regarded as dangerous, untrustworthy, promiscuous, and solely responsible for their infection and for the spread of AIDS. These conversations often took place in the

presence of HIV-positive individuals who concealed their HIV serostatus from the group for fear of being stigmatized.

Needless to say, measuring negative attitudes and opinions about HIV-positive individuals became an important objective for the larger survey. All HIV-negative participants in the survey were asked seven questions related to their opinions about HIV-positive individuals. Nearly half (49 percent) reported that HIV positive people were to blame for the spread of AIDS. Eighty-four percent reported that having sex with an HIV-positive person was dangerous. Nearly 20 percent believed that HIV-positive people couldn't be trusted, and nearly half believed HIV- positive individuals are more sexually promiscuous.

HIV stigma permits the dichotomization of the gay community into "good gays" and "bad gays."

When we examined negative attitudes reported by city, we found that HIV-related stigma was the lowest in New York (the city with the highest seroprevalence) and highest in Miami (the city with the lowest seroprevalence). This finding indicates that HIV stigma tends to be higher in situations where there are actually fewer opportunities for contact and interaction with HIV-positive individuals. As in the case of many types of social prejudice, increased exposure to HIV-positive individuals is associated with a lesser degree of HIV stigmatization. Nonetheless, as described below, HIV-positive individuals reported high levels of discrimination, even in cities like New York, where HIV-negative men reported more tolerant and accepting attitudes toward those infected.

In addition to asking HIV-negative participants to share their opinions about HIV-positive people, we asked HIV-positive individuals whether they ever experienced social discrimination due to their HIV-positive serostatus. Nearly half (46 percent) of all HIV-positive participants reported having been treated unfairly because of their serostatus. Forty-five percent believed that they had to hide their status to find acceptance from their families and friends. The majority of HIV-positive men (82 percent) thought sex partners might reject them if their sex partners knew their HIV serostatus. When we examined these trends by city among HIV-positive participants, unfair treatment and perception of possible rejection was reported most frequently in New York and least frequently in Miami. These findings have profound implications for our prevention efforts targeted at both HIV-positive and HIV-negative Latino gay men.

HIV stigma seems to have a specific social function for many HIV-negative Latino gay men: it allows some HIV-negative Latino gay men the opportunity to set themselves apart from other gay people. In focus group discussions some men were quite direct about not wanting to be associated with "those HIV-positive individuals who should have known better." HIV stigma permits the dichotomization of the gay community into "good gays" and "bad gays." This phenomenon emerges as a consequence of societal homophobia and is a typical by-product of specific intra-group dynamics that get created for all socially marginalized and culturally stigmatized groups. Peter Stallybrass and Allon White call this process "displaced abjection."[19]

Evolving HIV Prevention

A GUIDING FRAMEWORK FOR A NEW GENERATION OF INTERVENTIONS

We began with Paul Farmer's inspiring words, drawing our attention to the role that social forces play in producing health risks for individuals whose lives are deeply impacted by oppression and social inequality. We then provided the supporting scientific evidence, through a detailed presentation of findings from the study of Latino gay men. Our findings do indeed demonstrate a statistically significant link between experiences of social discrimination and the risk for HIV infection, a relationship typically neglected in prevention research, but long acknowledged by those who work on the front lines of community prevention services.

Our findings demand a conceptualization of "health risk" as a characteristic of socially produced contexts.

Now we must address the fact that our findings have profound implications for the next generation of HIV prevention approaches for Latino gay men, as well as for other gay men of color and for all those who suffer oppression and social discrimination. The findings demand, above all, a radical shift in our thinking about the nature of HIV risk and the way we craft HIV intervention strategies. We must first acknowledge that HIV risk is not simply an intra-individual factor or the property of certain individuals. In other words, HIV is not transmitted simply because there are risky individuals who practice risky behaviors on account of their individual personal deficits in morality, cognition or behavioral skills. Rather, our findings demand a conceptualization of "health risk" as a characteristic of socially produced contexts. These are social contexts of risk where individuals lose their power to enact their protective intentions, or where unsafe practices are perhaps the only viable and adaptive survival strategy. While individuals' values, cognitions, emotions and skills do become an integral part of the social contexts in which they participate, risk is the product of such social and contextual participation, rather than simply a personal trait that individuals bring along and enact across all situations and circumstances.

Contextual factors include, among other things, the range and type of sexual venues available to gay men, the codes of conduct and social norms that characterize those

venues, and the social location an individual occupies in relation to power and resources in those particular contexts. The point is that HIV prevention programs cannot simply target individual behaviors associated with HIV risk (e.g., condom use, perceived vulnerability to HIV, personal assessments of risk, communication skills, intention/motivation, self-esteem, self-efficacy, etc.).

Of utmost importance is that HIV prevention programs target those contexts of sexual risk—from contexts that connect sex and substances to contexts that promote hopeless and short-lived bouts of abstinence—that are directly shaped by factors of oppression and discrimination. Prevention work should help men: a) understand the social forces that produce the contexts of risk; b) critically analyze how and why those contexts impact their ability to protect themselves against HIV infection; and c) help them respond strategically in ways that result in health and well-being rather than in risk and disease.

HIV prevention must include strategies to counter racism, poverty, sexism, homophobia, and AIDS stigma, not only with faith, but also with scientific reassurance, that reducing their impact on individuals will result in a dramatic reduction of HIV.

The work requires that HIV prevention workers intervene both with interactional norms and strategies that help individuals "navigate" within and between social settings and institutions, acknowledging that risk behavior may at times emerge as genuine attempts to cope with and master, more or less successfully, highly stressful and discriminatory institutional environments. The focus of such interventions would be on understanding, explicitly teaching, and positively influencing the "rules" that govern social interaction within a particular social setting and influencing the "strategies" used by individuals within those settings to negotiate social exchange. Such interventions would recognize that individuals are not only influenced by their social situations but can and do in turn influence those situations.[20] Prevention work should also target directly those factors outside of individuals that directly impact their ability to protect themselves.

Working in collaboration with the owners and patrons of sex clubs, bars and bathhouses to positively influence social norms that promote altruism and a stronger sense of community responsibility is one potential avenue for intervention. Working to decriminalize sex work, organizing prostitutes, and facilitating their access to adequate health care and education is yet another. Launching social marketing initiatives that are designed to expose the relationships between homophobia, racism, poverty and HIV risk as a way to change individualistic discourses about the AIDS epidemic would directly and productively challenge the oppressive social factors that promote contexts of risk.

Encouraging greater familial acceptance and the presence of openly gay role models for gay youth could assist HIV prevention efforts in the long term.

This framework not only restores social context as a critical point for intervention, but it also legitimizes social action as a viable HIV prevention strategy. If social powerlessness and inequity produce patterned distributions of HIV/AIDS in the population, we as HIV prevention workers need to commit ourselves to working for social change. Policy reform and advocacy on behalf of people who are socially marginalized or disenfranchised is required to insure a more equitable distribution of power and resources. HIV prevention therefore must include strategies to counter racism, poverty, sexism, homophobia, and AIDS stigma, not only with faith, but also with scientific reassurance, that reducing their impact on

individuals will result in a dramatic reduction of HIV. In particular, encouraging greater familial acceptance and the presence of openly gay role models for gay youth could assist HIV prevention efforts in the long term. The positive correlation between the presence of gay role models as a youth and resiliency against HIV risk has major implications not only for education policy, but also for foster parenting for gay youth, and for the Boy Scouts.

Focusing simplistically on condom use, or on a promising vaccine, or on rapid access to antiviral treatment shortly after exposure—while disregarding the social forces that limit individuals' ability to protect themselves—amounts to treating only the symptom. It would be poor prevention work and poor medical practice. If we are to be effective in our fight against AIDS and any other public health tragedies that feed on human powerlessness, HIV prevention workers and advocates must also be agents of social and cultural change.

If we are to be effective in our fight against AIDS and any other public health tragedies that feed on human powerlessness, HIV prevention workers and advocates must also be agents of social and cultural change.

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Appendix

SAMPLING AND RECRUITMENT PROCEDURES FOR THE *NUESTRAS VOCES* STUDY

Between October 1998 and March 1999, as part of a multi-site study of Latino gay men in the US (named Nuestras Voces/Our Voices; R. Díaz, Principal Investigator and G. Ayala, Project Director), a probability sample of 912 Latino gay men was drawn from men entering social venues (bars, clubs and weeknight events identified as Latino and gay) in the cities of New York (n=309), Miami (n=302) and Los Angeles (n=301).

Briefly, the sampling procedures can be described in terms of the following steps:

1) A mini-ethnography was conducted in each city in order to determine the universe of social spaces defined as both Latino and gay, mapping their hours of operation seven days a week with an overall estimate of crowd size at peak times, level of acculturation of patrons, and predominant age group;

2) For New York City and Miami, we stationed a person ("counter") at each venue and instructed them to count the number of persons that entered during each fifteen-minute interval. For as many people as possible, counters would show incoming patrons a list of our universe of venues in the given city, and ask if this was the first time they were coming to one of these venues this week. Thus, in addition to recording the actual number of persons entering the venue at each 15-minute interval, counters kept track of the number of persons saying that this was their first time at the venues this week. At different times during the night, counters also looked around the venue and made an estimate of the house count. Based on this information, we broke the time of operation of each venue into meaningful 4-5 hour segments that we labeled "bar sampling units" (BSUs).

3) We then derived a measure of size for each BSU by multiplying the number of attendees by a ratio of those saying that this was their first night out divided by the total number of those interviewed (i.e., the number of persons who were briefly asked about their first time at the venues that week). The measure of "size" was thus our estimate of the number of first time attendees for that week during the given period of venue operation.

(For Los Angeles, we counted only a subset of the BSUs but did the house count everywhere. We then used the data from the previous two cities in conjunction with the house count information in LA to produce estimates of the number of first time attendees during each BSU that was then used as our measure of size. Note that for the purpose of sampling, this estimate was accurate enough since we would use the same measure of size which formed the probability of selection in the determination of the final weight of each BSU.)

4) Within each city all of the BSUs were ordered in such a way as to cluster them by age and acculturation and to distinguish between weekends and weekdays. This insured that the resulting sample would be balanced by age, acculturation and days of the week. A sample was drawn from each city based on the measure of size defined above.

5) We then assigned a target number of interviews for each BSU. We tried to apportion the 300 interviews uniformly across all BSUs. Exceptions were the very small BSU's and the very large disco nights. We then developed a sampling rate which was the estimated number of attendees divided by our targets. Note that although we used estimates to determine the probability of selecting the BSU and for selecting individuals within the BSU, the actual number that were later recruited in each venue depended on the number of eligible people that actually entered the bar during the recruitment period that happened several weeks after the counting sessions.

6) We then conducted a publicity campaign in order to advertise the study and, above all, to communicate and explain the random selection procedure which was somewhat foreign to men who typically see advertisements asking volunteers for participation in different studies. The catch-phrase: "If selected, will you say yes?" proved extremely useful to explain the nature of random selection. Posters and palm cards, in both English and Spanish, were distributed and placed widely in all the targeted venues.

7) In order to avoid the bias of recruiting frequent bar goers, we conducted all the recruitment and screening for the study within the period of one week in each city. We screened men according to four inclusion criteria: Latino ethnicity, city resident, non-heterosexual male, and first time at the bars this week at time of recruitment.

8) Each interview was then assigned a weight equal to the probability of the BSU being selected multiplied by the sampling rate of the given BSU. Since we knew the age and acculturation of those passing the screening and those completing the interview, we explored the possibility of doing a non-interview adjustment. However, we found that there was not enough of a difference to justify the complication.

Using the procedures listed above, we were able to approach a total of 5,097 men in the three cities. Of those, 3,086 (or 61 percent) agreed to be screened at the venue at time of recruitment. Of those whom we screened at the venues, 1546 (or 50 percent) met qualifying criteria for inclusion in the study. Of those who qualified, 1324 (or 86 percent) gave contact information to be interviewed. Appointments for individual interviews were made either at time of recruitment or through the contact information. Interviews were conducted individually, face-to-face, in different accessible locations (typically interviewing rooms of marketing research companies) in the three different cities. Interviewing stopped when we reached (actually, slightly exceeded) our goal, with an n=912 (n=309 in New York; n=302 in Miami; and n=301 in Los Angeles).

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Written by

Rafael M. Díaz
Center for Community Research
Institute on Sexuality, Inequality and Health
San Francisco State University

George Ayala
Center for Community Health
University of California Los Angeles

Reviewed by

David Acosta, AIDS Activities Coordinating Office,
Philadelphia Department of Public Health

Daniel Castillanos, Program Manager, Gay Men's Health Crisis

Julio Dicent, Alianza Dominicana

Andres Duque, Mano a Mano

Daniel Rivas, Bienestar

Ana Oliveira, Executive Director, Gay Men's Health Crisis

Juan Carlos Velazquez, LLEGÓ
(Latino/a Lesbian, Gay, Bisexual and Transgendered Organization)

Spanish translation by

Esther Carela

Edited by

Sean Cahill, Ph.D.
Steven Cordova
Laura Engle
Betsy Gressler
Ingrid G. Rivera

National Gay and Lesbian Task Force

Policy Institute *bestsellers*

Outing Age

PUBLIC POLICY ISSUES AFFECTING
GAY, LESBIAN, BISEXUAL AND TRANSGENDER ELDERS

This groundbreaking report reviews social science literature and explains what we do and do not know about the demographics of GLBT elders. *Outing Age* outlines major public policy issues facing GLBT seniors—including federal aging programs, disability, long-term care and caregiving, nursing homes, and Social Security—and presents recommendations for advocacy to move public policy toward equal treatment of this population. (November 2000; 152 pp; **$10.00**; www.ngltf.org /pub.html)

Redistricting

AND THE GAY, LESBIAN, BISEXUAL
AND TRANSGENDER COMMUNITY

A STRATEGY MEMO

The redrawing of district lines for seats in the US House of Representatives, state legislatures and city councils from 2001-2002 offers both opportunities and risks for the GLBT community. This strategy memo explains redistricting to local and state activists and offers concrete strategies for working with civil rights and women's groups to push for districts which make the election of a pro-GLBT candidate more likely. (February 2001; 58 pp; $10.00 www.ngltf.org/pub.html)

Transgender Equality

A HANDBOOK FOR ACTIVISTS
AND POLICYMAKERS

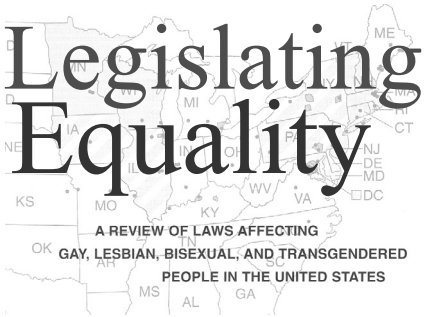
A handbook providing activists and policymakers with the tools they need to pass transgender-inclusive non-discrimination and anti-violence legislation. Written by Paisley Currah and Shannon Minter, with an introduction by Jamison Green. This handbook is an invaluable resource guide providing model legislative language, talking points, responses to frequently asked questions, and a comprehensive resource listing. (January 2000; 96 pp; **$10.00**; www.ngltf.org /pub.html)

Out and Voting II

THE GAY, LESBIAN, AND BISEXUAL VOTE
IN CONGRESSIONAL ELECTIONS, 1990-1998

An in-depth profile of the gay, lesbian, and bisexual voting bloc and the first-ever analysis of the impact of this emerging constituency in national congressional elections. By Dr. Robert Bailey of the Rutgers University School of Public Policy and Administration. Among the report's findings: out GLB voters comprise roughly 5% of the national electorate, and 8.8% of voters in cities of 500,000 or more. (January 2000; 54 pp; **$10.00**; www.ngltf.org /pub.html)

Legislating Equality



A REVIEW OF LAWS AFFECTING
GAY, LESBIAN, BISEXUAL, AND TRANSGENDERED
PEOPLE IN THE UNITED STATES

This comprehensive report, written by Policy Institute Research Fellow Wayne van der Meide, provides the most extensive description to date of local, county and state laws addressing GLBT equality. This report is an invaluable tool for activists, journalists and policymakers who require reliable facts on laws affecting GLBT people but lack the time, resources or desire to conduct primary research. (January 2000; 96 pp; **$10.00**; www.ngltf.org /pub.html)

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1973 to 1999

PUBLIC OPINION ON
GAY AND LESBIAN AMERICANS
MOVES TOWARD EQUALITY

This groundbreaking report, written by Alan Yang of the Department of Political Science at Columbia University, tracks public opinion trends over the last 26 years on various gay and lesbian rights issues including: employment and housing non-discrimination, family issues, marriage, adoption, and the military. (December 1999; 32pp; **$10.00**; www.ngltf.org/downloads/ yang99.pdf)

Domestic Partnership Organizing Manual

This manual, by Policy Institute Research Fellow Sally Kohn, provides comprehensive information on what domestic partnership benefits are, why employers should adopt these benefits, and how employees and citizens organize effectively for policy change. Sample policies and lists of who offers domestic partnership benefits are included. (May 1999; 140pp; **$10.00**; www.ngltf.org/pubs/dp_pubs.html)

Income Inflation

THE MYTH OF AFFLUENCE AMONG GAY, LESBIAN, AND BISEXUAL AMERICANS

This report, by Professor M.V. Lee Badgett, of the Department of Economics at the University of Massachusetts at Amherst, explores the pervasive and inaccurate notion that GLB people form an economic elite, insulated from discrimination by their wealth and disconnected from society at large by a special, privileged status. After examining data from seven different surveys, she finds that none support this stereotype. (November 1998; 23pp; **$10.00**; www.ngltf.org/downloads/income.pdf)

Calculated Compassion

HOW THE EX-GAY MOVEMENT SERVES THE RIGHT'S ATTACK ON DEMOCRACY

This report documents that the ex-gay movement serves as a camouflage for a retooled and reinvigorated assault by the religious right on legal anti-discrimination protections for gay, lesbian, bisexual, and transgender persons. Calculated Compassion is a joint publication of NGLTF, Political Research Associates, and Equal Partners in Faith. (October 1998; 30pp; **$6.00**; www.ngltf.org/downloads/calccomp.pdf)

Capital Gains and Losses 1999

A STATE BY STATE REVIEW OF GAY, LESBIAN, BISEXUAL, TRANSGENDER, AND HIV/AIDS-RELATED LEGISLATION

This report presents information about state legislative measures that sought to improve the quality of the lives of gay, lesbian, bisexual and transgendered (GLBT) people, as well as those that sought to denigrate and disenfranchise GLBT people. (December 1999; 175pp; **$10.00**; www.ngltf.org/99cgal/cgal99.html)
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1700 Kalorama Road, NW
Washington, DC 20009-2624
(202) 332-6483

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