The Intersection of Gender and Ethnicity in HIV Risk, Interventions, and Prevention

New Frontiers for Psychology

Gail E. Wyatt *University of California, Los Angeles*
Cynthia A. Gómez *San Francisco State University*
Alison B. Hamilton *University of California, Los Angeles and VA Greater Los Angeles Healthcare System*
Dellanira Valencia-Garcia *San Francisco State University*
Larry M. Gant and Charles E. Graham *University of Michigan*

This article articulates a contextualized understanding of gender and ethnicity as interacting social determinants of HIV risk and acquisition, with special focus on African Americans and Hispanics/Latinos—2 ethnic groups currently at most risk for HIV/AIDS acquisition in the United States. First, sex and gender are defined. Second, a conceptual model of gender, ethnicity, and HIV risk and resilience is presented. Third, a historical backdrop of gender and ethnic disparities is provided, with attention to key moments in history when notions of the intersections between gender, ethnicity, and HIV have taken important shifts. Finally, new frontiers in psychology are presented, with recommendations as to how psychology as a discipline can better incorporate considerations of gender and ethnicity as not only HIV risk factors but also as potential avenues of resilience in ethnic families and communities. Throughout the article, we promulgate the notion of a syndemic intersectional approach, which provides a critical framework for understanding and building the conditions that create and sustain overall community health by locating gendered lived experiences and expectations within the layered conceptual model ranging from the biological self to broader societal structures that define and constrain personal decisions, behaviors, actions, resources, and consequences. For ethnic individuals and populations, health disparities, stress and depression, substance abuse, and violence and trauma are of considerable concern, especially with regard to HIV risk, infection, and treatment. The conceptual model poses new frontiers for psychology in HIV policy, research, interventions, and training.

Keywords: HIV, gender, ethnicity, sociocultural, intersectionality

HIV/AIDS was first identified over 30 years ago as a life-threatening disease, and since then, extensive and costly efforts have been devoted to isolating factors (e.g., behaviors) that contribute to HIV transmission in order to develop effective interventions. Over time, however, it has become abundantly clear that behaviors contributing to HIV cannot be examined in isolation, and they are not particularly amenable to "quick fix" interventions that do not address the contexts in which those behaviors occur (Adimora, Schoenbach, & Floris-Moore, 2009; Aral, Adimora, & Fenton, 2008). Instead, behaviors need to be understood—and addressed—in the contexts of personal identity, communities, cultures, and broader sociopolitical environments. Two key interrelated social constructs to consider in a contextualized understanding of HIV-related behaviors are gender and ethnicity.

In U.S.-based HIV/AIDS research and policy, gender and ethnicity are considered "risk factors" due to the fact that males and females from specific ethnic groups have historically been variably at risk for HIV and more or less burdened by a preponderance of HIV infection (Centers for Disease Control and Prevention [CDC], 2012). What was once a disease concentrated in White, gay, affluent men has now become a disease concentrated in non-affluent popu-

---

Editor's note. This article is one of eight in the May–June 2013 special issue of the *American Psychologist* titled "HIV/AIDS: Social Determinants and Health Disparities." Hortensia Amaro, University of Southern California, was the scholarly lead for the special issue. The issue is dedicated to the late John R. Anderson, PhD, former senior director of the APA Office on AIDS and a national and international leader in the scholarly, practice, and policy work devoted to the prevention of the disease and the psychosocial care of persons living with HIV/AIDS.

Authors' note. Gail E. Wyatt, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles; Cynthia A. Gómez, Health Equity Institute, San Francisco State University; Alison B. Hamilton, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, and VA Greater Los Angeles Healthcare System; Dellanira Valencia-Garcia, Health Equity Institute, San Francisco State University; Larry M. Gant and Charles E. Graham, School of Social Work, University of Michigan.

We thank John Williams and Thomas Parham for their assistance with literature, and Louise Datu and Melanie Cuesta for their assistance with article preparation.

Correspondence concerning this article should be addressed to Gail E. Wyatt, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, Semel Institute for Neuroscience and Human Behavior, 760 Westwood Plaza, 38-232 NPI, Box 175919, Los Angeles, CA 90024-1759. E-mail: gwyatt@mednet.ucla.edu

Vol. 68, No. 4, 247–260 DOI: 10.1037/a0032744

Gail E. Wyatt

lations of color, with Black men accounting for 42% of new HIV infections among men and Black women accounting for 64% of new infections among women, despite only representing 11% and 12% of the U.S. population, respectively (CDC, 2012). In 2009, Hispanics/Latinos represented 16% of the population but accounted for 20% of new HIV infections, though recent evidence suggests a decline in HIV incidence among Hispanics/Latinos, particularly among Puerto Ricans, a subpopulation historically at high risk (Espinoza, Hall, & Hu, 2012). The subpopulations most affected by new HIV infections in 2009 were White men who have sex with men (MSM), followed closely by Black MSM, and then Hispanic/Latino MSM, Black heterosexual women, Black heterosexual men, and then Latina and White heterosexual women. At some point in their lives, approximately one in 16 Black men will be diagnosed with HIV infection, as will one in 32 Black women (CDC, 2012). Furthermore, among transgender women, the national HIV prevalence is 27.7% (with 45%–65% being unaware of their status). More than one in four transgender women have become infected with HIV (vs. 8% among non-transgender women; Herbst et al., 2008). Given the current epidemiology of HIV/AIDS, the "intersection" (Bowleg, 2012) of gender and ethnicity is of paramount importance in our understanding of HIV risk, infection, treatment, and prevention.

Gender and ethnicity are unlike behavioral risk factors that can potentially be addressed in interventions; they are not deleterious behaviors but are instead complex, socially constructed, interconnected aspects of human experience. Given their centrality to HIV risk and transmission, the task for psychologists in intervention and prevention research is to better understand the intersection of gender and ethnicity, specifically the sociocultural factors that support traditional definitions and roles of gender identity in ethnic and sexual minority communities, and the contradictions that emerge when addressing HIV risk in underserved communities. In addition, psychologists must often consider gender and ethnicity-related sociocultural factors in the context of other HIV-related issues such as substance abuse, sexual violence, and mental illness.

This is one of few articles that provides a sociocultural perspective on gender and ethnic disparities for HIV interventions and prevention within the context of other endemic challenges in underserved communities. Much extant research acknowledges gender, religion, and culture as important contributors to health determinants that are "features of and pathways by which societal conditions affect health" (Krieger, 2001, cited in Poundstone, Strathdee, & Celantano, 2004, p. 22; see also Ford & Airhihenbuwa, 2010; Yamada & Brekke, 2008). However, very little research directly addresses specific gender norms and expectations and the relevance of social support, family, and ethnic and religious communities to gender and ethnic disparities in HIV/AIDS treatment and prevention. Factors that pertain to HIV prevention and reduction of mental illness and trauma-related symptoms—such as substance abuse, depression, and interpersonal or community-level violence—are also not adequately addressed in the current demonstration of evidence-based interventions (DEBIs) that are endorsed by the CDC (Wyatt, Williams, Gupta, & Malebranche, 2012).

The goal of this article is to contextualize gender and ethnicity as social determinants of HIV risk and transmission, with a special focus on African Americans and Hispanics/Latinos—two ethnic groups currently at most risk for HIV/AIDS acquisition. We begin by defining sex and gender, and then we present our conceptual model, which we believe to be unique in its inclusive conceptualization of gender (as not only female but also male and other gender identities) and its consideration of gender and ethnicity as not only risk factors but also potential resilience factors. Then we point out key moments in history when notions of the intersections of gender, ethnicity, and HIV have taken pivotal and important shifts. We provide some examples of how gender roles and identities are expressed in ethnic minority communities, and the implications of gendered norms for HIV risk, transmission, treatment, and prevention. Finally, we pose new frontiers for psychology in HIV prevention and interventions and important next steps to integrate gender, ethnicity, and other factors that influence and enhance risk reduction and resilience among populations most at risk for HIV transmission.

Defining Sex and Gender

Although the constructs of sex and gender are distinct, they are often used interchangeably, raising serious concerns in health research and confusion about how findings are to be implemented (Krieger, 2003; Lorber, 1994; Nowatzki & Grant, 2011). The term *sex* refers to the biological, chromosomal, hormonal, and physiological characteristics of being male or female either at birth or before (Pryzgoda &

Cynthia A. Gómez

Chrisler, 2000; World Health Organization, 2012). At first glance, this term appears seemingly easy to define—one is either born a male or a female. However, a definition of biological sex is not always dichotomous because it does not include people of intersex status and with other chromosomal and hormonal variations (Kuhnle & Krahl, 2002). Nonetheless, a binary conceptualization of biological sex (male/female) continues to drive most social and legal categories and is used in the organization of societies, often underlying social control, hierarchies, power distribution, and gendered schema (Lorber, 1994; West & Zimmerman, 1987).

Whereas sex is typically defined in biological terms, *gender* is a socially constructed concept that does not refer to biological or chromosomal characteristics (Lorber, 1994). Gender requires a culture-specific learning process consisting of socially constructed roles and behaviors, upheld and enacted by individuals, which in turn provide the social rules for the conduct of people in society (Gupta, 2000; Lorber, 1994; West & Zimmerman, 1987). Gender is part of a societal codebook for how men and women should act in their respective roles in their communities. Moreover, gender is an important organizational structure that helps define gendered activities and access to power and resources, with notable gender inequalities (Baker-Miller, 1986). Issues of power inequalities and group subordination within the social construction of gender have become increasingly important in the transmission of HIV and other sexually transmitted diseases (Gupta, 2000).

Distinct from people with biological sex consistent with gender identity and gender expression, transgender persons face a particularly distinct intersection of biological sex and gender construction. Transgender persons are those whose gender identity and gender expression differs from their biological sex at birth (Gay and Lesbian Alliance Against Defamation, 2010; Institute of Medicine, 2011). It is important to recognize that this term does not describe sexuality, sexual behavior, or sexual orientation. Transgender persons may be male-to-female or female-to-male and may self-identify as heterosexual, homosexual, bisexual, or any number of other gender identities (Stryker, 1998). The recent Institute of Medicine (2011) report, *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*, acknowledges that data specifically on the proportion of transgender people in the U.S. population are sorely lacking. However, the CDC reports that transgender communities in the United States are among the groups at highest risk for HIV infection, as noted above (CDC, 2011).

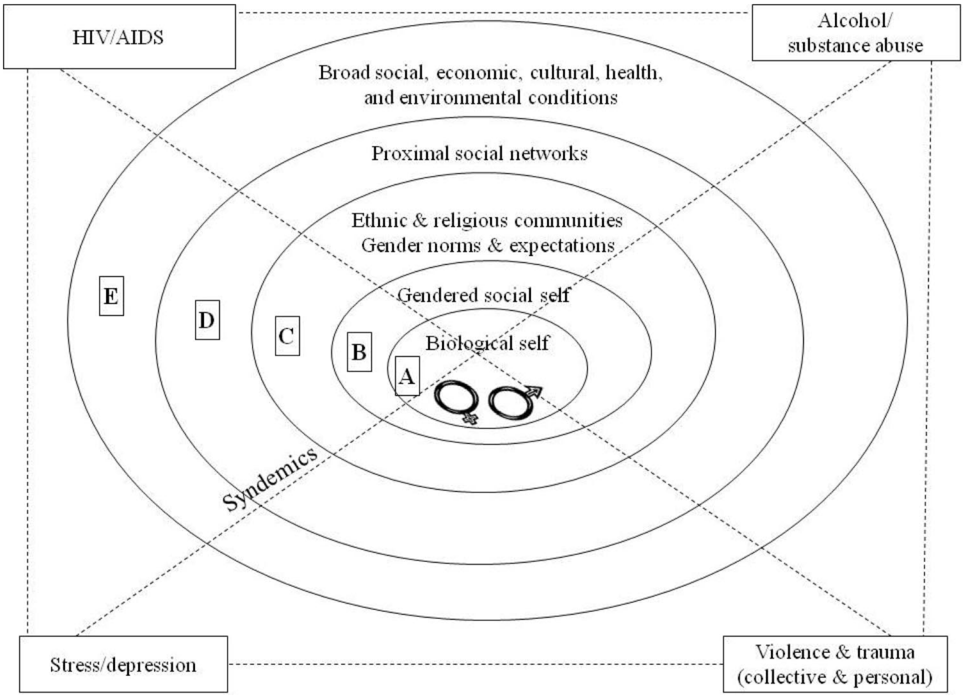
Gender, as a social determinant of health, contributes to inequitable social, economic, and psychological experiences that can lead to differential health risks and outcomes (Keleher, 2004). In sum, gender—a dynamic of social expectations, social position, and a social history that impacts us throughout our life course—can serve as both an asset and a liability in HIV acquisition, particularly among ethnic communities in the United States. When ethnicity and HIV risks are added to the complexities of gender, our inability to address these three issues in combination has created disparities in how we currently address them.

A Conceptual Model of Gender, Ethnicity, and HIV Risk and Resilience

Our conceptual model (see Figure 1) depicts the intersectionality of gender and ethnicity, as shaped and influenced by ethnic and religious communities, proximal social networks, and broader social contexts. One of the solutions to minimizing gender disparities is to recognize the limitations associated with isolating gender as a sole contributor to health outcomes. Intersectionality assumes race, class, and gender are interacting systems of social and power relations within which all members of society are located (Bilge, 1999), and presupposes that the simultaneous workings of these power relations shape social locations, experiences, and identities and cannot be simply added or subtracted to any concept (Cole, 2009). Within each layer of our model, there are norms and expectations for behavior, as well as opportunities to ascribe to or veer away from these norms. We move beyond the biological assignment of sex at birth (Circle A) to the social construction of the gendered, ethnic self (Circle B) as embedded in communities, some of which are ascribed according to sociocultural norms (Circle C) and some of which are chosen according to personal and social preferences (Circle D).

As depicted by the dotted lines surrounding and intersecting the circles, our model incorporates the notion of syndemics. For ethnic individuals and populations struggling under multiple interactive constraints and opportunities, health disparities, stress and depression, substance abuse, and violence and trauma (depicted in the boxes in the corners of the model) are of considerable concern, especially with regard to HIV risk, infection, and treatment.

Figure 1
Syndemic Intersectional Model of Gender, Ethnicity, and HIV Risk and Resilience



A *syndemic* is defined as "two or more epidemics . . ., interacting synergistically and contributing, as a result of their interaction, to excess burden of disease in a population" (Singer & Clair, 2003, p. 425). Initially introduced by anthropologist Merrill Singer, the substance abuse, violence, and AIDS—or SAVA—syndemic was conceptualized as inextricable and mutually reinforcing connections between three conditions that disproportionately afflict those living in poverty in U.S. cities (Singer, 1994, 1996). Our model posits a syndemic intersectional approach, locating gendered lived experience and expectations within broader societal structures (Circle E) that define and constrain personal decisions, behaviors, actions, resources, and consequences. A syndemic intersectional approach provides a critical framework for understanding and building the conditions that create and sustain overall community health (Egan et al., 2011).

Ethnic and Religious Communities (Circle C) and Social Networks (Circle D)

Families and communities typically expect adherence to traditional or gender neutral roles in the interest of the community over the individual. This is illustrated by the African philosophical statement, "I am because we are and because we are, I am" (Mbiti, 1970, p. 141). The endorsement of particular gender norms by important role models and leaders is often expressed in ways that are rarely perceived as protective and affirming to the larger community, and sometimes leadership and larger communities express very different perspectives. For example, 2012 Gallup Polls of gay rights views in the United States indicate that about half of Blacks approve of same sex marriage (50%) and believe that gay/lesbian relations are acceptable (50%) and should be legalized (59%; Gallup Poll, 2012). Though comparable polls for Black congregations do not yet exist, the Black church has been characterized as one of the main perpetrators of homophobia in the Black community (Ward, 2005). Although there are interventions aimed at providing ministers with HIV-related facts and skills to address prevention within a religious context (Vasquez, 2012), there are too few interventions that balance attention to cultural norms and religious beliefs with attention to sexual practices that either heighten HIV-related risk or promote sexual health.

The need for family members to assume gendered responsibilities to ensure family cohesion and well-being does not necessarily change with sexual orientation. For sexual minorities, family and community support are important, but can come with a price. The contradictions between what is expected and what is happening are still major sources of HIV-related conflict and consequent risk-taking practices, especially for MSM and women who value their relationships with partners and families over self-protection, for example, in cases of abuse (Wyatt, 2009). Furthermore, African American men and women at

Alison B. Hamilton

highest risk for HIV often do not identify as same gender-loving or gay, due to stigma as well as economic and emotional dependence. This has serious consequences in terms of acknowledging risks, getting tested for HIV/AIDS, and adhering to HIV medications to prevent or treat symptoms of HIV. The reality of living with a chronic disease threatens the acceptance and social support of family, friends, and communities (Williams, Wyatt, Resell, Peterson, & O'Brien, 2004).

Similarly, the threat of HIV/AIDS to the U.S. Latino community highlights important aspects of respect (*respeto*), importance of maintaining relationships (*personalismo*), and connectedness with family and community (*familismo*); these aspects of culture may indeed serve as both protective and risk factors for HIV. Gender nonconformity can lead to social and familial ostracism and discrimination (Carrillo, 2002; Valencia-Garcia, Starks, Strick, & Simoni, 2008). However, the support of family and community in the face of gender nonconformity can have powerful, positive effects on self-esteem and mental health (Simoni, Montoya, Huang, & Goodry, 2005). For many Latinos, what your family and society thinks of you—*que dira la gente* (what will people say)—is often a powerful influence on behavior. However, though specific cultural factors may be contextually important when examining the risk of HIV among Latinos living in the United States, not all subgroups adhere to or endorse culturally specific factors in a uniform fashion, as is also the case in African American communities in the United States. Important ethnic subgroup differences exist among these heterogeneous populations, which vary on levels of acculturation, immigration and sociopolitical status, economic context (e.g., income and education), and health (Carter-Pokras & Zambrana, 2001; Vega & Alegria, 2001).

The sociocultural approach to gender presented in this article is distinct from much contemporary HIV prevention theory and research due to our focus on gender-relevant roles, locations, functions, and situations. Ethnicity and gender have a special association among ethnic people, in particular because of discrimination and stigma. When discrimination of any nature occurs, individuals are overlooked and not valued; the right to be oneself is negated and often repeatedly so. To counter negative assumptions about personal credibility, individuals might use visible ethnic characteristics of facial features, skin color, hair texture, language and accent, dress, and behavior in ways that affirm their presence and identity (Wyatt, 1990). Other attributes like education, language spoken, and racial socialization (e.g., strategies that are taught to address perceived discrimination and promote self-validation) can serve as buffers to experiences of discrimination (Harris-Britt, Valrie, Kurtz-Costes, & Rowley, 2007).

For both men and women, gender roles exist on a continuum and HIV affects individuals across this spectrum. We have often failed to examine and highlight the flexible and fluid nature of gender roles for men and women, especially within a cultural context. For example, though masculine roles exist in most cultures, the term *machismo* historically denoted certain racial characteristics, often one-sided and negative, which are then used to stereotype and minimize the role of Latino men (Gutmann, 1996; Mirande, 1997). Yet, prior research suggested that as few as 10% of Latinos identify with traditional, unidimensional *machismo*, with the majority of respondents instead endorsing identification with other dimensions such as contemporary masculinity, conflicted/compassionate *machismo*, and contemporary *machismo* (Torres, Solberg, & Carlstrom, 2002). More recently, Arciniega, Anderson, Tovar-Blank, and Tracey (2008) empirically demonstrated the dimensions of (a) *traditional machismo*, with a focus on hypermasculinity and aggression, and (b) *caballerismo*, which reflected characteristics of affiliation, chivalry, social responsibility, and emotional engagement.

Despite this recent research on more complex constructions and expressions of masculinity, more complex notions of gender roles have not permeated the discipline of psychology, and they have not been incorporated into HIV research, treatment, and prevention. Instead, "conventional wisdom" has prevailed (Poundstone et al., 2004), undermining the nuanced reality of negotiated masculinity among Latinos and African American men, and thereby placing men of color at risk for excess disease, illness, and mortality. In other words, the socially proscribed version of masculinity may contribute to low help-seeking and high risk-taking. For example, heterosexual Black males who embrace cultural norms of masculinity—characterized in the United States by power and dominance—might equate manhood with having multiple and concurrent sexual female partners (Bowleg et al., 2011; Marable, 1984; Parham, White, & Ajamu, 1999). Through these types of pursuits, some African American men may attempt to confirm a comparative and competitive prowess, particularly if they lack opportunities for an adequate education

Dellanira Valencia-Garcia

and skills to earn an income (White & Cones, 1999). Masculine socialization has also been found to impact HIV sexual behavior and partner selection among Black MSM (Bowleg et al., 2011; Malebranche, Fields, Bryant, & Harper, 2009). For example, young Black MSM have been found to engage in more HIV risk-taking sexual behavior (e.g., unprotected anal intercourse) with males perceived as masculine, in the belief that they are less risky than those overtly related to gay lifestyle (Fields et al., 2012). Association with overtly feminine males is typically stigmatized and linked to White, flamboyant gay culture (Fields et al., 2012).

In sum, for men and women of color, reducing HIV risk might fly in the face of expected gendered behavior and gender norms. This challenge is consonant with the conundrum posed by Parham (1999, p. 795) regarding African Americans: "How does one maintain a sense of cultural integrity in a world that does not support nor affirm our humanity as people of African descent?" This same question could be asked for other ethnic communities who experience persistent contradictions between cultural and societal expectations and demands.

Missing from most interventions is an acknowledgment that gender and cultural values are important to integrate into curricula that address how to establish and maintain an identification with characteristics that promote positive identities and the resultant self-efficacy to reduce risks as an HIV-positive individual (El-Bassel, Gilbert, et al., 2010; Valencia-Garcia et al., 2008). These examples of the intersections of gender, ethnicity, and HIV-related risks can provide insight into why heterosexual and same gender-loving individuals may embrace traditional gender roles as a testament to their resilience. They may, however, also resist the possible stigmatized identities as a person at risk for or living with HIV, routine HIV/STI testing, and daily adherence to HIV medications, even in the face of heightened risks for HIV/AIDS acquisition or transmission (Wyatt, 2009).

Broad Societal Conditions (Circle E) and Syndemics

The gender expectations and gender role dynamics described above are realized within broader social, economic, and environmental conditions. These dynamics, including perceived discrimination, can contribute to poor health and risk of disease transmission due to high levels of community, relationship and personal violence and related trauma, alcohol and substance abuse, unaddressed mental health needs, and lack of health care access and equal opportunities for HIV treatment (Institute of Medicine, 2002; see also Wu et al., 2010). Research on gender differences in violence and trauma, substance abuse, and mental health is extensive (see, e.g., Brady & Randall, 1999), as is research on racial/ethnic differences. However, few studies address gender and ethnic differences in syndemics (i.e., interacting conditions) that are highly implicated in HIV risk. In an effort to explain the higher incidence of HIV among Black women (compared to White and Latina women), Tillerson (2008) conducted a systematic review and found that Black women are no more likely to have unprotected sex, have multiple sexual partners, or use drugs than women of other racial/ethnic groups. Tillerson also found some studies that suggest that Black women are more likely to have risky sex partners and STDs, and that Black men are less likely to disclose their same-sex behavior to female partners. However, overall, these findings failed to explain the greater burden of HIV among Black women. Tillerson (2008) and others (e.g., Bogart, Wagner, Galvan, & Klein, 2010; Latkin & Knowlton, 2005) have recommended greater examination of these and other macro-level social, ecological, and behavioral factors such as poverty, health care access, and perceived and actual discrimination to explain racial/ethnic and gender disparities in HIV incidence.

Key Moments in the History of HIV, Gender, and Ethnicity

The following pivotal points in the history of HIV/AIDS illustrate how gender and ethnicity have been consistently implicated in HIV risks and transmission.

1. AIDS was initially considered as a "gendered" (i.e., male) and social disease, but with racial/ethnic overtones. Medical and government experts described the condition as the gay-related immunodeficiency disease (GRID) because it occurred predominantly among gay men. The fact that women were also presenting with HIV-related symptoms was largely ignored (Masur, Murry, & Jones, 1982). HIV had not yet been discovered, but the negative portrayal and prejudice about the types of men and women becoming infected were also becoming widespread. People talked about a "4-H club" of persons at risk for AIDS: homosexuals, hemophiliacs, heroin addicts, and Haitians—although hemophiliacs were quickly dropped

Larry M. Gant

and substituted with "hookers"—underscoring the view that it was really the undesirables of American society that were impacted (Black, 1986; Callen, 1983; Goldstein, 1983). The Haitian vulnerability was never well-defined, but the inclusion of a specific ethnic group in this initial list fueled the intersection of race/ethnicity, gender, and sexual orientation as a target of stigma and discrimination.

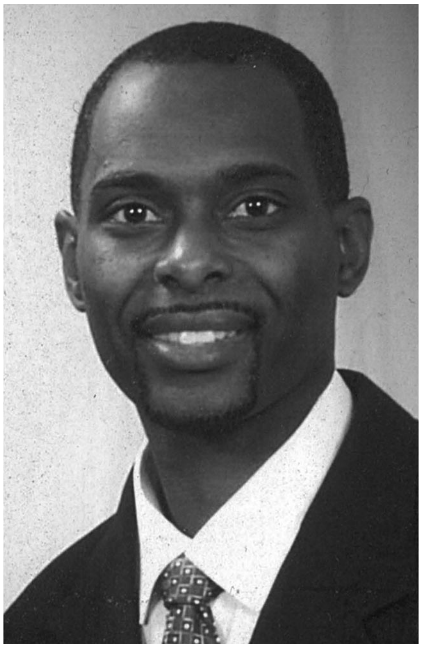
2. Prevention interventions in the United States started with grassroots, non-governmental efforts by community-based organizations (CBOs) and health providers (Altman, 1984; Arno, 1986; Shilts, 1987). The assumption behind these efforts was that these groups knew the pertinent communities and how to reach those at risk. These efforts originated in 1982 before there was a definitive understanding of the mechanisms of transmission of the newly named Acquired Immune Deficiency Syndrome (AIDS), and they were culturally specific to the populations of gay men, injection drug users, and commercial sex workers—populations not likely to be the focus of government-sponsored interventions (Altman, 1984; Ickovics, Morrill, Beren, Walsh, & Rodin, 1994; Kalichman, 1996). Structural interventions and policies being considered by local governments were specific to a "disease control" model, such as the closure of gay bathhouses and the exclusion of blood donation by groups considered being at risk for AIDS (Shilts, 1987).

3. Social determinants of HIV risk (including gender and ethnicity) were absent from initial research and prevention intervention efforts in part because a public health/epidemiological model became the impetus for the eradication of this new epidemic. In this model, the distribution of disease considers demographic characteristics (e.g., sex, age, geography) and the determinants of the observed distribution, which, for HIV, became predominantly a focus on the identification of sex- and drug-related behavior patterns leading to HIV transmission. Initial studies of gay men (McKusick, Hortsman, & Coates, 1985) and injection drug users (IDUs; Des Jarlais, Friedman, & Hopkins, 1985) focused on identifying the scope and determinants of HIV transmission risk behaviors, and potential strategies to reduce those behaviors.

Interventions in the early 1980s began in the major urban epicenters (New York, San Francisco, Los Angeles, and Miami) and included outreach, telephone information hotlines, and group education activities delivered by newly formed community groups such as the Gay Men's Health Crisis in New York and the San Francisco AIDS Foundation in California.

4. The identification of HIV in 1984 and subsequent development of the HIV antibody test in 1985 increased the government's national media campaign and other educational efforts. Surgeon General Koop's historic 1987 report (Koop, 1987), delivered in a more abbreviated version to every American household in 1988 (Koop, 1988), was one of the most candid and well-explained messages regarding mechanisms of transmission. Unfortunately, both versions included language that allowed heterosexuals, particularly women, to erroneously assume they were not at risk. In the 1987 report, Koop noted, "Couples who maintain mutually faithful monogamous relationships (only one continuing sexual partner) are protected from AIDS through sexual transmission" (p. 16). In the 1988 report, Koop went even further in this message, stating "Married people who are uninfected, faithful and don't shoot drugs are not at risk" (p. 4). The invisibility of HIV risk for women was promulgated in the popular media, such as a January 1988 article in a popular women's magazine, *Cosmopolitan*, which featured an editorial by Dr. Robert E. Gould, a psychiatrist, who reassured women that there was little to no risk of infection via heterosexual intercourse. Although an editorial in *Cosmopolitan* did not constitute a scientific publication, it underscored the *zeitgeist* of the perception that women were not at risk.

5. AIDS-defining conditions specific to women such as cervical cancer were not included by the CDC in the AIDS-spectrum diagnosis until 1993 (Hader, Smith, Moore, & Holmberg, 2001). In 1987, the CDC created a list of AIDS-defining illnesses that were a proxy for severe immunosuppression, especially defective cell-mediated immunity. Kaposi's sarcoma (KS) and high-grade non-Hodgkin's lymphoma (NHL) were included in this list and most common among HIV-infected men. By 1993, CDC had recognized an increased prevalence of cervical dysplasia (a precursor lesion for cervical cancer) among HIV-infected women, and studies also documented that a higher prevalence of cervical dysplasia among HIV-infected women was associated with greater immunosuppression (CDC, 1992). This delay in recognizing women-specific AIDS-related illnesses deprived women of critical health and financial resources (i.e., an AIDS diagnosis would provide disability and health care benefits) that were available to men for over a decade before they were available to women living with HIV. Consequently, gender inequities and low



Charles E. Graham

social status of women have been evident throughout the course of the epidemic. Even though women were at risk and becoming infected with HIV, they were primarily viewed as vectors for the spread of HIV, either to their unborn fetuses or to heterosexual men via sex work (Gómez, 2011). Furthermore, early attention to transgender women and men was primarily about their HIV risk in relation to gender identity disorder (Pang, Pugh, & Catalan, 1994) or as vectors through transsexual or transvestite prostitution (Boles & Elifson, 1994; Elifson et al., 1993; Modan et al., 1992).

6. The CDC AIDS surveillance system showed an inconsistent use of gender, sexual behavior, sexual orientation, and injection drug use in classifying modes of HIV acquisition for men and for women. The ability to classify mode of transmission for every new incidence of HIV requires the newly infected person to be able to identify and disclose the most likely route of HIV acquisition. In the context of a frightening and deadly epidemic, this may have been an appropriate expectation in theory, but the immediate level of stigma associated with AIDS and the subsequent chronicity of HIV/AIDS would soon bring into question the wisdom of this classification system, and today provides great challenges in its level of accuracy and its contribution to the persistent perception that women are minimally at risk. For example, if a woman is found to have HIV, she will be asked about her own behaviors and about her male partner's behaviors. If she reports that she has *ever* injected drugs and also reports that she has a male partner infected with HIV, she will be classified as a woman who became infected via injection drug use, even if she believes she got infected through heterosexual sex and was not currently injecting drugs. This is because the CDC has a hierarchy of risk classification, meaning that if you have multiple potential avenues of HIV risk, you will be classified under the highest risk level, in this case, injection drug use. However, under the classification for men, there is a combined classification for men who have sex with men and inject drugs. Therefore a gender bias was embedded early in the classification system by not allowing women to have an "injection drug use and sex with a man" classification that might have acknowledged the broader role of gender hidden within the drug use classification.

The initial and widespread perception that women with HIV in the United States were "bad" women—mostly IDUs and/or sex workers—was ultimately challenged in 1995 when heterosexual contact was documented by the CDC as the main source of HIV acquisition for women (Branson et al., 2006; Hader et al., 2001). This clarified the fact that that the majority of women were becoming infected through heterosexual contact with a high-risk male partner whose HIV status was likely unknown to them, and represented the failure of Surgeon General Koop's assumed monogamy.

7. As AIDS incidence rates continued to rise exponentially among all genders, the need for more systematic and comprehensive HIV prevention strategies that could reach diverse audiences was apparent. Most HIV prevention interventions focused solely on male condom use during sex and non-sharing of injection equipment (Burkett, 1996; Patton, 1996; Sobo, 1995). Even screening questions about risk behaviors were typically generic, focusing on number of sex partners and condom use. Sexual practices and drug-sharing were not contextualized, the focus was on individuals and not relationships, and sex was assumed to be consensual. Interventions did not address violent or coercive relationships that might increase risks for HIV/AIDS (Wyatt et al., 2011, 2004).

8. Attention to gender dynamics and contexts of sexual encounters emerged with the realization that women were not the "condom wearers." Interventions focusing on women negotiating condom use with a male partner (Kalichman, Kelly, Hunter, Murphy, & Tyler, 1993), or negotiating clean injection practices with drug-sharing partners (Des Jarlais et al., 1985), were eventually criticized for focusing on individuals rather than the relational, structural, and environmental context of risk-taking involved in sexual and drug-using behaviors (Amaro, 1993; Gómez & Marin, 1996; Wyatt, 1994, 2009). As the epidemic continued to ravage through ethnic communities, so too did the need to understand these more complex and interrelated dynamics of ethnicity and gender.

9. Critical gaps within interventions and research included the role of power dynamics, social structures, and the influences of racism, sexism, classism, and transphobia. Social, economic, and political influences were identified as playing a role in the disparities underlying the increasing infection rates in ethnic communities (De La Cancela, 1989). However, despite these issues, attention to gender and power imbalances as well as to the cultural issues pertinent to risk and protective factors among ethnic communities continued to be absent in interventions (Amaro, 1995; Gómez, 2011; Wyatt et al., 2004, 2012).

10. Over 20 years into this pandemic, the role of culture, gender, and power imbalances in relationships as well as the numerous societal and economic factors impacting disadvantaged groups most affected by HIV continue to be ignored. A recent review of HIV/AIDS interventions published between 1988 and 2010 that met guidelines of the CDC's HIV/AIDS Prevention Research Synthesis-Compendium of HIV Prevention Interventions with Evidence of Effectiveness (CDC, 2001) reported that only 34 of 166 interventions included some definition of the culture of the targeted groups, or attempted to address some aspect of cultural beliefs and practices that might conflict with prevention messages about HIV/AIDS transmission (Wyatt et al., 2012). These findings highlight our need to understand what about culture matters and what about gender can serve to protect and empower both men and women, especially among ethnic minority populations who carry the burden of HIV.

11. As we move toward implementing biological methods of treatment and the first National HIV/AIDS Strategy for the United States (White House Office of National AIDS Policy, 2010), there has been growing concern that consideration of gender and ethnicity is still absent, even though HIV clinical trials are now incorporating treatments that affect the physiology and biology of individuals. As noted by the Positive Women's Network (2012, p. 2),

> inadequate research has been conducted to date to make a determination on efficacy of Truvada [an HIV medication now being used preventively among high-risk individuals] as PrEP [Pre-Exposure Prophylaxis] among women, factors that impact adherence among women, as well as safety for women at various stages of their life spans.

Approved by the Federal Drug Administration in July 2012 as the first HIV prevention pill (Knox, 2012), Truvada continues to be a controversial and complicated approach to preventing HIV, with little known about its safety, utility, feasibility, sustainability, and affordability in diverse populations.

As of 2011, there are no reported biological sex differences in adverse events with integrase, fusion, or CCR5 inhibitors. However, among women, virologic failure rates are more related to antiretroviral therapy (ART)-related complications (Aziz & Smith, 2012); women experience biologically linked side effects (Mave, Gahunia, Frontini, Clark, & Mushatt, 2011) and severe side effects with highly active antiretroviral therapy (HAART; see review by Floridia, Giuliano, Palmisano, & Vella, 2008), and women appear to discontinue HAART at greater rates than men. It is also important to note that virologic failure rates in the United States vary widely by population group, with African American women and men at far greater risk for virologic failure than their White American counterparts (Weintrob et al., 2009).

Addressing Gender and Ethnicity as Social Determinants of HIV: New Frontiers in Psychology

Although psychology as a discipline has been at the forefront of HIV/AIDS prevention, efforts to forge new ground should consider multiple levels of change agents within policy, research, clinical practice, and training. We offer specific recommendations and examples within each of these areas.

Policy Changes

Gender theories have moved us beyond an earlier dichotomous view of gender identity to recognize multi-dimensional and multi-layered concepts, as described above. Biological, social, and personal history aspects of sex and gender identity may matter for understanding health differences. Accordingly, data collection protocols should allow for collection of the key aspects of these factors. Still, many researchers, health departments, funders, and government agencies do not allow for or consider the identification or reporting of a gender continuum, and currently there is no standardized method for capturing sex and gender identity data that accurately reflects these complexities.

Policy changes in systematic data collection by local and federal health agencies could lead the way in establishing effective methodologies for the measurement of gender. For example, the San Francisco Department of Public Health (SFDPH), in collaboration with social/medical research scientists, recently developed a set of principles and guidelines on how to collect, categorize, report, and use sex and gender data in their programs. The guiding principles are as follows:

1. To the extent that sex and gender identity are markers of health or risk differences, they should be identified as well as possible in data collection and reporting.
2. Biological, social, and personal history aspects of sex and gender identity may matter for understanding health differences. Data collection protocols should allow for concise collection of the most key aspects of these factors.
3. Naming of sex and gender identity should allow for both consistency and relevancy.
4. Categorization should allow for both compliance and comparability.
5. A single set of core sex and gender categories that are aligned with state and federal minimum reporting requirements are needed and should be developed.
6. Sexual orientation, behavior, and practice data should be gathered through other specific questions and not inferred from sex and gender identity.

These guidelines are a first attempt by SFDPH to systematically address the need for data collection in order to improve information, data consistency, and understanding of their populations' sex and gender identities. These changes in data collection practices will be increasingly important for biomedical interventions that also require behavior change, especially for those populations whose behaviors are inconsistent with the manner in which they identify themselves as well as with the way that they are biologically defined. Psychologists can contribute and participate in the development of these more precise measurements, and they should always include them in their own research and clinical practice protocols.

A second policy change related to data collection would be to advocate for the revision of risk hierarchies used by the CDC for HIV and AIDS surveillance, as previously discussed, to better reflect the mode of infection (i.e., sex with a man; sharing a needle) rather than risk groups (i.e., men who have sex with men) as is current practice. Additionally, increasing access to other intersectional data in HIV surveillance such as social class or income would improve contextual analyses beyond a sole focus on race/ethnicity and gender as risk factors.

Public health policies that require use of evidence-based interventions for HIV risk reduction should move beyond condom use promotion strategies and include interventions that focus on quality of life over time. Psychologists can join with other professionals to help develop interventions that include components addressing job training, microfinance skills, and attainment of basic educational skills such as reading and writing for literacy among highly vulnerable and at risk populations; these enhancements can have a profound impact on the populations most at risk.

The American Psychological Association (APA) has a well-established and effective Public Interest Directorate that "applies psychology to the fundamental problems of human welfare and social justice and the promotion of equitable and just treatment of all segments of society through education, training, and public policy" (see http://www.apa.org/pi/) and that should continue to address relevant issues that promote gender, racial, and ethnic equalities within society. Accordingly, psychologists can take advantage of the wealth of resources provided by APA to stay current on relevant policy changes regarding social determinants of health.

Changes in Research Directions

The research needed today to end the epidemic must go beyond individual-level change and must stop using gender, race, and ethnicity as proxies for explanatory risk factors. Instead, HIV prevention and intervention research must understand the intersection of gender and ethnicity, and at times, the contradictions that emerge when addressing HIV risk in underserved communities. Below are some specific examples of needed changes in research direction.

Investigators should broaden their understanding of gender-specific HIV prevention interventions, so that the needs of men at risk for or living with HIV can gain more attention. Ethnic minority men face social and economic disadvantages as well as complex gender roles that place them at heightened risk for infection, as discussed above (Amaro, Vega, & Valencia, 2001). The social pressures regarding masculinity and heterosexism in our society create risks for men that further impact risks for women (Paternostro, 1998; Valencia-Garcia et al., 2008), yet these aspects of gender continue to be overlooked in most interventions to date. Recently, research with couples at risk for or living with HIV/AIDS has been successful in addressing gender-specific needs within the context of interventions aimed at the couple supporting each other (El-Bassel, Jemmott, et al., 2010). Further, psychologists can review the methods by which global programs, such as International Planned Parenthood Federation, effectively include men in gender programs, interventions, and policy work. Incorporating men as essential constituents in gender research yields products of more nuanced and complex effective education and action programs regarding health, HIV, and men's involvement with family and community empowerment (International Planned Parenthood Federation, 2008, 2010).

Research that addresses gender differences in risk for HIV/AIDS transmission needs to contextualize sexual and drug-related risk-taking practices to better understand some of the personal, relationship, circumstantial, cultural, religious, and community-level expectations that contradict risk reduction efforts. For example, interventions should include a focus on learning to cope with personal trauma as a result of sexual or physical violence, regardless of gender or sexual orientation. These programs need to address how health-damaging coping strategies such as substance abuse and medical mistrust due to inequities and mistreatment in the health care system can compromise medical adherence and health care access. Teaching effective coping skills should be essential components of "basic readiness" prior to enrollment into biomedical or biobehavioral interventions that address risky practices in relationships, social networks, and communities. This is especially required for survivors of violence and trauma. Future research should also embrace feminist gains, gendered analyses, and findings regarding more complex understandings of gender roles and experiences. Attention should be directed to studying the limitations of models focusing solely on women's empowerment and limits of dichotomizing men's and women's roles in personal, sexual, and family issues. Furthermore, priority should be given to studies of transgender men and women, the context of their risks and resilience, and interventions that acknowledge different definitions and roles of gender identity and health promotion.

We need research expertise to develop interventions to bridge the gap between the adherence to rich, traditional messages about gender and its value in ethnic communities, along with other survival strategies, and what is needed in the 21st century in order to avoid disease transmission. Much of the change in thinking about some of these concepts will have to come from within the communities, religious institutions, and groups at most risk for HIV/AIDS, and changes to structural and institutional barriers are also being made via policy. We need to create more opportunities for investigators with diverse educational and ethnic backgrounds to conduct comprehensive research that addresses ethnic, cultural, and gender disparities (Ginther et al., 2011).

Clinical Practice

Issues related to gender inequalities as well as associated psychological distress and trauma are often seen in clinical practice. Psychologists with expertise in understanding gender disparities and the importance of maintaining ethnic, cultural, religious socialization in families and communities as sources of resilience for ethnic minorities need to be acknowledged (Smedley, 2012). Clinicians should seek consultation with colleagues experienced in this area for appropriate and competent treatment.

Although psychologists may not directly address pharmacologic HIV treatment and care, an understanding of gender and biological factors may lead to different intervention approaches for persons living with HIV disease. Knowing the probabilities of virologic failure for specific populations may lead to different ways to present information to persons at possible risk for HIV infection and different ways to formulate interventions that take differential effects of medications into consideration.

Last, psychology licensing boards need to assess for competence in gender as well as culturally and clinically relevant assessment practices and skills in order to heighten the level of knowledge of practicing psychologists regarding how to address and align conflicting beliefs, messages and practices that may compromise risk reduction efforts and gender-related disparities (Yamada & Brekke, 2008). Just as the APA needs an administrative office that ensures cultural competence of psychologists for licensure, also needed is a standardized assessment and evaluation of gender competence, with a special emphasis on the intersection of gender, ethnicity, and mental health concerns.

Undergraduate- and Graduate-Level Training in Psychology

As part of the curriculum, undergraduate- and graduate-level psychology training programs need to include courses and training that address and examine gender disparities as social determinants of health, including mental health. Students need to better understand how pivotal historical points have contributed to gender and health disparities for different ethnic and cultural groups. We need to minimize barriers created by gender inequities by adapting models like the one proposed in this article to balance, broaden, and implement a new understanding of the intersectional components of gender and its influence on HIV/AIDS-related health issues. These changes in training will increase competence in diversity training and practice.

Conclusion

This is one of few articles to examine gender disparities along a continuum that includes both biological and social constructions that intersect with ethnicity and cultural beliefs and practices for some of the groups at most risk for and living with HIV/AIDS. We recognize that this review does not discuss all ethnic groups at growing HIV acquisition risk that deserve a similar discourse about gender and ethnic disparities of their own; this article only begins this conversation. This article does affirm that traditional gender roles and values in ethnic minority communities need to be acknowledged and understood. Although some cultural values may be disempowering for women and should not be promulgated, others may be drawn from as strengths in HIV prevention efforts that promote self-protection and sexual health; fundamental principles of human rights and dignity serve as an important backdrop to consideration of cultural values related to gender (United Nations Population Fund, 2008).

Psychologists can have an active role in better understanding gender norms and expectations in our relationships, families, institutions, and in the larger society. Furthermore, we must increase our understanding of how gender and ethnicity-based inequalities are developed, supported, and sustained within our cultural and social structures and policies, and how perceived discrimination contributes to health disparities (Smedley, 2012). Once we achieve a better understanding of these mechanisms of influence, we will be better prepared to intervene beyond individual-level behavior change, and find alternative forms of family, community, and social acceptance beyond ethnically based gender norm conformity. If we refine the basic training of psychologists, along with the clinical practice tools and research skills that will improve the work that they do, new frontiers will be initiated so that gender and ethnic disparities in HIV can finally be eliminated.

REFERENCES

Adimora, A. A., Schoenbach, V. J., & Floris-Moore, M. A. (2009). Ending the epidemic of heterosexual HIV transmission among African Americans. *American Journal of Preventive Medicine, 37,* 468–471. doi:10.1016/j.amepre.2009.06.020

Altman, L. K. (1984, April 24). Researchers believe AIDS virus is found. *The New York Times,* pp. C1, C3.

Amaro, H. (1993, July 19–21). *Health data on Hispanic women: Methodological limitations.* Paper presented at the 1993 Public Health Conference on Records and Statistics, Washington, DC.

Amaro, H. (1995). Love, sex, and power. Considering women's realities in HIV prevention. *American Psychologist, 50,* 437–447. doi:10.1037/0003-066X.50.6.437

Amaro, H., Vega, R., & Valencia, D. (2001). Gender, context, and HIV risk among Latinos. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 301–324). San Francisco, CA: Jossey-Bass.

Aral, S. O., Adimora, A. A., & Fenton, K. A. (2008). Understanding and responding to disparities in HIV and other sexually transmitted infections in African Americans. *Lancet, 372,* 337–340. doi:10.1016/S0140-6736(08)61118-6

Arciniega, G. M., Anderson, T. C., Tovar-Blank, Z. G., & Tracey, T. J. G. (2008). Toward a fuller conception of Machismo: Development of a traditional Machismo and Caballerismo Scale. *Journal of Counseling Psychology, 55,* 19–33. doi:10.1037/0022-0167.55.1.19

Arno, P. S. (1986). The nonprofit sector's response to the AIDS epidemic: Community-based services in San Francisco. *American Journal of Public Health, 76,* 1325–1330. doi:10.2105/AJPH.76.11.1325

Aziz, M., & Smith, K. (2012). Treating women with HIV: Is it different than treating men? *Current HIV/AIDS Reports, 9,* 171–178. doi:10.1007/s11904-012-0116-x

Baker-Miller, J. (1986). *Toward a new psychology of women.* Boston, MA: Beacon Press.

Bilge, S. (1999, February 4–9). *Smuggling intersectionality into the story of masculinity: Some methodological challenges.* Paper presented at the Feminist Research Methods conference, University of Stockholm, Sweden. Retrieved from http://www.kvinfo.su.se/femmet09/papers/pdf/Bilge_revised.pdf

Black, D. (1986). *The plague years: A chronicle of AIDS, the epidemic of our times*. New York, NY: Simon & Schuster.

Bogart, L. M., Wagner, G. J., Galvan, F. H., & Klein, D. J. (2010). Longitudinal relationships between antiretroviral treatment adherence and discrimination due to HIV-serostatus, race, and sexual orientation among African-American men with HIV. *Annals of Behavioral Medicine, 40,* 184–190. doi:10.1007/s12160-010-9200-x

Boles, J., & Elifson, K. W. (1994). The social organization of transvestite prostitution and AIDS. *Social Science & Medicine, 39,* 85–93. doi:10.1016/0277-9536(94)90168-6

Bowleg, L. (2012). The problem with the phrase *women and minorities*: Intersectionality—An important theoretical framework for public health. *American Journal of Public Health, 102,* 1267–1273. doi:10.2105/AJPH.2012.300750

Bowleg, L., Teti, M., Massie, J. S., Patel, A., Malebrance, D. J., & Tschann, J. M. (2011). 'What does it take to be a man? What is a real man?': Ideologies of masculinity and HIV sexual risk among Black heterosexual men. *Culture, Health & Sexuality, 13,* 545–559. doi:10.1080/13691058.2011.556201

Brady, K. T., & Randall, C. L. (1999). Gender differences in substance use disorders. *Psychiatric Clinics of North America, 22,* 241–252. doi:10.1016/S0193-953X(05)70074-5

Branson, B. M., Handsfield, H. H., Lampe, M. A., Janssen, R. S., Taylor, A. W., Lyss, S. B., & Clark, J. E. (2006). Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recommendations and Reports, 55,* 1–17. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

Burkett, E. (1996). *The gravest show on earth: America in the age of AIDS*. Boston, MA: Houghton Mifflin Company.

Callen, M. (1983). Remarks of Michael Callen to the New York Congressional Delegation, 1983. Retrieved from http://www.thebody.com/content/art13573.html

Carrillo, H. (2002). *The night is young: Sexuality in Mexico in the time of AIDS*. Chicago, IL: The University of Chicago Press.

Carter-Pokras, O., & Zambrana, R. E. (2001). Latino health status. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 23–54). San Francisco, CA: Jossey-Bass.

Centers for Disease Control and Prevention. (1992, December 18). 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm

Centers for Disease Control and Prevention. (2001). Compendium of HIV prevention interventions with evidence of effectiveness. Retrieved from http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm

Centers for Disease Control and Prevention. (2011). HIV among transgender people fact sheet. Retrieved from http://www.cdc.gov/hiv/transgender/

Centers for Disease Control and Prevention. (2012). HIV in the United States: At a glance. Retrieved from http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV_at_a_glance.pdf

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist, 64,* 170–180. doi:10.1037/a0014564

De La Cancela, V. (1989). Minority AIDS prevention: Moving beyond cultural perspectives towards sociopolitical empowerment. *AIDS Education and Prevention, 1,* 141–153.

Des Jarlais, D. C., Friedman, S. R., & Hopkins, W. (1985). Risk reduction for the acquired immunodeficiency syndrome among intravenous drug users. *Annals of Internal Medicine, 103,* 755–759.

Egan, J. E., Frye, V., Kurtz, S. P., Latkin, C., Chen, M., Tobin, K., . . . Koblin, B. A. (2011). Migration, neighborhoods, and networks: Approaches to understanding how urban environmental conditions affect syndemic adverse health outcomes among gay, bisexual and other men who have sex with men. *AIDS and Behavior, 15,* 35–50. doi:10.1007/s10461-011-9902-5

El-Bassel, N., Gilbert, L., Witte, S., Wu, E., Hunt, T., & Remien, R. H. (2010). Couple-based HIV prevention in the United States: Advantages, gaps, and future directions. *JAIDS: Journal of Acquired Immune Deficiency Syndromes, 55*(Suppl. 2), S98–S101. doi:10.1097/QAI.0b013e3181fbf407

El-Bassel, N., Jemmott, J. B., Landis, J. R., Pequegnat, W., Wingood, G. M., Wyatt, G. E., . . . the NIMH Multisite HIV/STD Prevention Trial for African American Couples Group. (2010). National Institute of Mental Health Multisite Eban HIV/STD prevention intervention for African American HIV serodiscordant couples: A cluster randomized trial. *Archives of Internal Medicine, 170,* 1594–1601. doi:10.1001/archinternmed.2010.261

Elifson, K. W., Boles, J., Posey, E., Sweat, M., Darrow, W., & Elsea, W. (1993). Male transvestite prostitutes and HIV risk. *American Journal of Public Health, 83,* 260–262. doi:10.2105/AJPH.83.2.260

Espinoza, L., Hall, H. I., & Hu, X. (2012). Diagnoses of HIV infection among Hispanics/Latinos in 40 states and Puerto Rico, 2006–2009. *JAIDS: Journal of Acquired Immune Deficiency Syndromes, 60,* 205–213. doi:10.1097/QAI.0b013e31824d9a29

Fields, E. L., Bogart, L. M., Smith, K. C., Malebranche, D. J., Ellen, J., & Schuster, M. A. (2012). HIV risk and perceptions of masculinity among young Black men who have sex with men. *Journal of Adolescent Health, 50,* 296–303. doi:10.1016/j.jadohealth.2011.07.007

Floridia, M., Giuliano, M., Palmisano, L., & Vella, S. (2008). Gender differences in the treatment of HIV infection. *Pharmacologic Research, 58,* 173–182. doi:10.1016/j.phrs.2008.07.007

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine, 71,* 1390–1398. doi:10.1016/j.socscimed.2010.07.030

Gallup Poll. (2012). U.S. acceptance of gay/lesbian relationships is the new normal. Retrieved from http://www.gallup.com/poll/154634/Acceptance-Gay-Lesbian-Relations-New-Normal.aspx

Gay and Lesbian Alliance Against Defamation. (2010). Transgender glossary of terms. Retrieved from http://www.glaad.org/reference/transgender

Ginther, D. K., Schaffer, W. T., Schnell, J., Masimore, B., Liu, F., Haak, L. L., & Kington, R. (2011, August 19). Race, ethnicity, and NIH research awards. *Science, 333,* 1015–1019. doi:10.1126/science.1196783

Goldstein, A. (1983, June 12). AIDS fear hits gay populace doctors: More deaths likely. *Miami Herald*. Retrieved from http://nl.newsbank.com/nl-search/we/Archives?p_action=list&p_topdoc=31

Gómez, C. A. (2011). Preventing HIV in U.S. women and girls: A call for social action. *Women's Health Issues, 21,* S287–S294. doi:10.1016/j.whi.2011.07.012

Gómez, C. A., & Marin, B. V. (1996). Gender, culture, and power: Barriers to HIV prevention strategies for women. *Journal of Sex Research, 33,* 355–362. doi:10.1080/00224499609551853

Gupta, G. (2000). *Gender, sexuality and HIV/AIDS: The what, the why and the how*. Paper presented at the 13th International AIDS Conference, Durban, South Africa.

Gutmann, M. C. (1996). *The meanings of being macho: Being a man in Mexico City*. Berkeley: University of California Press.

Hader, S. L., Smith, D. K., Moore, J. S., & Holmberg, S. D. (2001). HIV infection in women in the United States: Status at the millennium. *JAMA: Journal of the American Medical Association, 285,* 1186–1192. doi:10.1001/jama.285.9.1186

Harris-Britt, A., Valrie, C. R., Kurtz-Costes, B., & Rowley, S. J. (2007). Perceived racial discrimination and self-esteem in African American youth: Racial socialization as a protective factor. *Journal of Research on Adolescence, 17,* 669–682. doi:10.1111/j.1532-7795.2007.00540.x

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior, 12,* 1–17. doi:10.1007/s10461-007-9299-3

Ickovics, J. R., Morrill, A., Beren, S. E., Walsh, U., & Rodin, J. (1994). Limited effects of HIV counseling and testing for women. *JAMA: Journal of the American Medical Association, 272,* 443–448. doi:10.1001/jama.1994.03520060043030

Institute of Medicine. (2002). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academies Press.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

International Planned Parenthood Federation. (2008). *Men and sexual and reproductive health (IPPF Policy Paper)*. Retrieved from http://www.ippf.org/en/What-we-do/Access/IPPF+policy+on+men+and+SRH.htm

International Planned Parenthood Federation. (2010). Men are changing: Case study evidence on work with men and boys to promote gender equality and positive masculinities. Retrieved from http://www.ippf.org/NR/rdonlyres/36B8FD71-BB77-45D6-8424-B887323D6ED7/0/MenAreChanging.pdf

Kalichman, S. C. (1996). *Answering your questions about AIDS*. doi:10.1037/10496-000

Kalichman, S. C., Kelly, J. A., Hunter, T. L., Murphy, D. A., & Tyler, R. (1993). Culturally tailored HIV-AIDS risk reduction messages targeted to African-American urban women: Impact on risk sensitization and risk reduction. *Journal of Consulting and Clinical Psychology, 61,* 291–295. doi:10.1037/0022-006X.61.2.291

Keleher, H. (2004). Why build a health promotion evidence base about gender? *Health Promotion International, 19,* 277–279. doi:10.1093/heapro/dah313

Knox, R. (2012, July 17). Deciding on Truvada: Who should take the HIV prevention pill? Retrieved from http://www.npr.org/blogs/health/2012/07/17/156868446/deciding-on-truvada-who-should-take-new-hiv-prevention-pill

Koop, C. E. (1987). *Surgeon General's report on acquired immune deficiency syndrome*. Washington, DC: U. S. Department of Health and Human Services.

Koop, C. E. (1988). *Understanding AIDS* (Report No. HHS-88-8404). Washington, DC: U.S. Department of Health and Human Services.

Krieger, N. (2003). Genders, sexes, and health: What are the connections—And why does it matter? *International Journal of Epidemiology, 32,* 652–657. doi:10.1093/ije/dyg156

Kuhnle, U., & Krahl, W. (2002). The impact of culture on sex assignment and gender development in intersex patients. *Perspectives in Biological Medicine, 45,* 85–103. doi:10.1353/pbm.2002.0011

Latkin, C. A., & Knowlton, A. R. (2005). Micro-social structural approaches to HIV prevention: A social ecological perspective. *AIDS Care, 17*(Suppl. 1), 102–113. doi:10.1080/09540120500121185

Lorber, J. (1994). *Paradoxes of gender*. New Haven, CT: Yale University Press.

Malebranche, D., Fields, E. L., Bryant, L. O., & Harper, S. (2009). Masculine socialization and sexual risk behaviors among Black men who have sex with men: A qualitative exploration. *Men and Masculinities, 12,* 90–112. doi:10.1177/1097184X07309504

Marable, M. (1984). The Black male: Searching beyond stereotypes. *National Scene, 53,* 5–30.

Masur, H., Murry, H. W., & Jones, T. C. (1982). Effect of hydrocortisone on macrophage response to lymphokine. *Infection and Immunity, 35,* 709–714.

Mave, V., Gahunia, M., Frontini, M., Clark, R., & Mushatt, D. (2011). Gender differences in HIV drug resistance mutations and virological outcome. *Journal of Women's Health, 20,* 117–122. doi:10.1089/jwh.2009.1846

Mbiti, J. (1970). *African religions and philosophy*. Garden City, NY: Anchor Books.

McKusick, L., Hortsman, W., & Coates, T. J. (1985). AIDS and sexual behavior reported by gay men in San Francisco. *American Journal of Public Health, 75,* 493–496. doi:10.2105/AJPH.75.5.493

Mirande, A. (1997). *Hombres y machos: Masculinity and Latin culture*. Boulder, CO: Westview Press.

Modan, B., Goldschmidt, R., Rubinstein, E., Vonsover, A., Zinn, M., Golan, R., . . . Gottlieb-Stematzky, T. (1992). Prevalence of HIV antibodies in transsexual and female prostitutes. *American Journal of Public Health, 82,* 590–592. doi:10.2105/AJPH.82.4.590

Nowatzki, N., & Grant, K. R. (2011). Sex is not enough: The need for gender-based analysis in health research. *Health Care for Women International, 32,* 263–277. doi:10.1080/07399332.2010.519838

Pang, H., Pugh, K., & Catalan, J. (1994). Gender identity disorder and HIV disease. *International Journal of STD & AIDS, 5,* 130–132.

Parham, T. A. (1999). Invisibility syndrome in African descent people: Understanding the cultural manifestations of the struggle for self-affirmation. *The Counseling Psychologist, 27,* 794–801.

Parham, T. A., White, J. L., & Ajamu, A. (1999). *The psychology of Blacks: An African- centered perspective*. Englewood Cliffs, NJ: Prentice Hall.

Paternostro, S. (1998). *In the land of God and man: Confronting our sexual culture*. New York, NY: Dutton.

Patton, C. (1996). *Fatal advice: How safe-sex education went wrong*. Durham, NC: Duke University Press.

Positive Women's Network. (2012). [Letter to the Antiviral Drugs Advisory Committee, Food and Drug Administration]. Retrieved from http://www.pwn-usa.org/wp-content/uploads/2011/02/PWNPrEPRecs4-30-2012.pdf

Poundstone, K. E., Strathdee, S. A., & Celentano, D. D. (2004). The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. *Epidemiological Reviews, 26,* 22–35. doi:10.1093/epirev/mxh005

Pryzgoda, J., & Chrisler, J. C. (2000). Definitions of gender and sex: The subtleties of meaning. *Sex Roles, 43,* 553–569. doi:10.1023/A:1007123617636

Shilts, R. (1987). *And the band played on: Politics, people, and the AIDS epidemic*. New York, NY: St. Martin's Press.

Simoni, J. M., Montoya, H. D., Huang, B., & Goodry, E. J. (2005). Social support and depressive symptomatology among HIV-positive women: The mediating role of self-esteem and mastery. *Women & Health, 42,* 1–15.

Singer, M. (1994). AIDS and the health crisis of the U.S. urban poor: The perspective of critical medical anthropology. *Social Science & Medicine, 39,* 931–948. doi:10.1016/0277-9536(94)90205-4

Singer, M. (1996). A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. *Free Inquiry, 24,* 99–110.

Singer, M., & Clair, S. (2003). Syndemics and public health: Reconceptualizing disease in bio-social context. *Medical Anthropology Quarterly, 17,* 423–441.

Smedley, B. D. (2012). The lived experience of race and its health consequences. *American Journal of Public Health, 102,* 933–935. doi:10.2105/AJPH.2011.300643

Sobo, E. J. (1995). *Choosing unsafe sex: AIDS-risk denial among disadvantaged women*. Philadelphia: University of Pennsylvania Press.

Stryker, S. (1998). The transgender issue: An introduction. *GLQ: A Journal of Lesbian and Gay Studies, 4,* 145–158.

Tillerson, K. (2008). Explaining racial disparities in HIV/AIDS incidence among women in the U.S.: A systematic review. *Statistical Medicine, 27,* 4132–4143. doi:10.1002/sim.3224

Torres, J. B., Solberg, V. S. H., & Carlstrom, A. H. (2002). The myth of sameness among Latino men and their machismo. *American Journal of Orthopsychiatry, 72,* 163–181. doi:10.1037/0002-9432.72.2.163

United Nations Population Fund. (2008). Human rights principles. Retrieved from http://www.unfpa.org/rights/principles.htm

Valencia-Garcia, D., Starks, H., Strick, L., & Simoni, J. M. (2008). After the fall from grace: Negotiation of new identities among HIV-positive women in Peru. *Culture, Health & Sexuality, 10,* 739–752.

Vasquez, E. (2012). Of faith and compassion: Black leaders urge the church to tend to its people. Retrieved from http://positivelyaware.com/2012/12_01/FaithAndCompassion.shtml

Vega, W. A., & Alegria, M. (2001). Latino mental health and treatment in the United States. In M. Aguirre-Molina, C. Molina, & R. Zambrana (Eds.), *Health issues in the Latino community* (pp. 179–208). San Francisco, CA: Jossey-Bass.

Ward, E. G. (2005). Homophobia, hypermasculinity and the U.S. Black church. *Culture, Health & Sexuality, 7,* 493–504. doi:10.1080/13691050500151248

Weintrob, A. C., Grandits, G. A., Agan, B. K., Ganesan, A., Landrum, M. L., Crum-Cianflone, N. F., . . . the IDCRP HIV Working Group. (2009). Virologic response differences between African Americans and European Americans initiating highly active antiretroviral therapy with equal access to care. *JAIDS: Journal of Acquired Immune Deficiency Syndromes, 52,* 574–580. doi:10.1097/QAI.0b013e3181b98537

West, C., & Zimmerman, D. (1987). Doing gender. *Gender & Society, 1,* 125–151. doi:10.1177/0891243287001002002

White, J. L., & Cones, J. H. (1999). *Black man emerging: Facing the past, seizing a future in America*. New York, NY: Routledge.

White House Office of National AIDS Policy. (2010). *National HIV/AIDS strategy for the United States*. Retrieved from http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf

Williams, J. K., Wyatt, G. E., Resell, J., Peterson, J., & O'Brien, A. (2004). Psychosocial influences on HIV risks among HIV positive African American and Latino MSM with a history of CSA. *Cultural*

Diversity and Ethnic Minority Psychology, 10, 268–286. doi:10.1037/1099-9809.10.3.268

World Health Organization. (2012). What do we mean by “sex” and “gender”? Retrieved from http://www.who.int/gender/whatisgender/en/

Wu, L. T., Ling, W., Burchett, B., Blazer, D. G., Shostak, J., & Woody, G. E. (2010). Gender and racial/ethnic differences in addiction severity, HIV risk, and quality of life among adults in opioid detoxification: Results from the National Drug Abuse Treatment Clinical Trials Network. *Substance Abuse and Rehabilitation, 1,* 13–22. doi:10.2147/SAR.S15151

Wyatt, G. E. (1990). Sexual abuse of ethnic minority children: Identifying dimensions of victimization. *Professional Psychology: Research and Practice, 21,* 338–343. doi:10.1037/0735-7028.21.5.338

Wyatt, G. E. (1994). The sociocultural relevance of sex research. *American Psychologist, 49,* 748–754. doi:10.1037/0003-066X.49.8.748

Wyatt, G. E. (2009). Enhancing cultural and contextual intervention strategies to reduce HIV/AIDS among African Americans. *American Journal of Public Health, 99,* 1941–1945. doi:10.2105/AJPH.2008.152181

Wyatt, G. E., Hamilton, A. B., Myers, H. F., Ullman, J. B., Chin, D., Sumner, L. A., . . . Liu, H. (2011). Violence prevention among HIV-positive women with histories of violence: Healing women in their communities. *Women’s Health Issues, 21,* S255–S260. doi:10.1016/j.whi.2011.07.007

Wyatt, G. E., Longshore, D., Chin, D., Carmona, J. V., Loeb, T. B., Myers, H. F., . . . Rivkin, I. (2004). The efficacy of an integrated risk reduction intervention for HIV-positive women with child sexual abuse histories. *AIDS and Behavior, 8,* 453–462. doi:10.1007/s10461-004-7329-y

Wyatt, G. E., Williams, J. K., Gupta, A., & Malebranche, D. (2012). Are cultural values and beliefs included in U.S. based HIV interventions? *Preventive Medicine, 55,* 362–370. doi:10.1016/j.ypmed.2011.08.021

Yamada, A. M., & Brekke, J. (2008). Addressing mental health disparities through clinical competence not just cultural competence: The need for assessment of sociocultural issues in the delivery of evidence-based psychosocial rehabilitation services. *Clinical Psychology Review, 28,* 1386–1399. doi:10.1016/j.cpr.2008.07.006