African American Attitudes toward Gay Males: Faith-based Initiatives and Implications for HIV/AIDS Services

Anthony J. Lemelle, Jr.

In African American communities attitudes toward gay males deserve specific concern. ANOVA analysis and t tests indicate that African American females and males have significantly different attitudes toward gay males across different religious preferences. Males have significantly more negative attitudes.

INTRODUCTION

A disproportionate number of African Americans have HIV/AIDS. AIDS was stigmatized in special ways in the African American community (Cohen, 1999; Fullilove and Fullilove, 1999). Community-based organizations, particularly those agencies concerned with drug abuse, owned AIDS in the early days of the epidemic, but religious leaders kept their distance (Morales and Fullilove, 1992; Fullilove and Fullilove, 1999; Weinstein, 1990). Fullilove and Fullilove (1999) studied AIDS attitudes among African American clergy in the New York City area and found that at the heart of the faith-based organizations' immobility was stigma toward those who were substance users and abusers and homosexual males; yet, the greatest stumbling block to action was attitudes toward homosexuality (Fullilove and Fullilove, 1996; Fullilove and Fullilove, 1999).

National welfare policy proposals are now being debated and implemented that might shift responsibility for some social work services to faith-based organizations. In June 2000, leaders of black faith-based organizations met in Tuskegee, Alabama in an effort to plan action for combating AIDS. More than 300 bishops, pastors, priests and layman attended the meeting from

ANTHONY J. LEMELLE, Jr., Ph.D. teaches in the Department of Africology at the University of Wisconsin-Milwaukee.

JOURNAL OF AFRICAN AMERICAN STUDIES, 2004, 7(4): 59-74

across the United States and frank discussion about homosexuality in black faith-based organizations took place. One of the leaders, Calvin Butts, president of the Council of Churches of the City of New York, said churches must teach sex education. He added, "You can't be hypocritical about this, because it's killing us" (Henderson, 2000). These efforts among others have become referred to as "faith-based initiatives." The term faith-based organization is used in this article as an umbrella term encompassing any organization that is motivated by faith, affiliated with a faith tradition, or that incorporates religion in its activities in any way. The term applies, therefore, to a range of organizational forms including houses of worship as well as separately incorporated nonprofits.

Early HIV/AIDS demographics indicate the disease was largely concentrated among males who have sex with males and intravenous illicit drug users. The Center for Disease Control and Prevention (CDC) estimates that approximately 40,000 people per year are infected with HIV (CDC, 2000b). Forty-six percent of the new infection cases where the cause of transmission is known, are in men who have sex with men. African Americans represent 64 percent of all reported cases. About half of the men becoming infected are African American. Sixty-three percent of all new cases in women are African American. Among pediatric AIDS cases, African Americans represent 66 percent of them (CDC, 2000b).

Historical discrimination and segregation contributed to the development of black faith-based organizations. These organizations often provided political and social work services (Pinkney, 2000). The development of black faith-based organizations historically existed outside of the development of white ones. "Denied the opportunity to participate as equals in the religious life and other institutions of the larger society, black people organized their own religious denominations as a means of coping with social isolation they encountered" (Pinkney, 2000, p. 119). Black faith-based organizations largely have been an accommodating force in U.S. history. Social scientist Gunnar Myrdal wrote, "Undoubtedly the great bulk of the Southern Negro Preachers advocated complete acceptance of slave status" (Myrdal, 1944, p. 860). This conservatism remained with religious movements as they joined the civil rights movement of the 1950s. Martin Luther King, Jr. indicated that he had been "chastened" by the conservatism of black preachers in Montgomery (King, 1958). This conservatism is noted throughout the African American community but it shifted at times of heightened conflict with the dominant culture. Examples of this in-

clude Nat Turner's rebellion (Marable, 1989), the civil rights movement (Morris, 1984) and the rise of liberation theology (Cone, 1989). At these historical points, black faith-based organizations strategically realigned their ideology to accommodate forces of social change.

HIV/AIDS challenged black faith-based organizations in new ways (Chambré, 2001). It challenged religious conceptions of both family life and human sexuality (Lemelle and Harrington, 1998). Is it possible for individuals who identify with faith-based organizations to demonstrate positive attitudes toward homosexual males? Which religious preference groups might be more suited for providing for the welfare of homosexual males? By way of introduction, I will briefly review the literature on faith-based organizations and HIV/AIDS as well as HIV/AIDS in the black population. I will then present data on attitudes toward gay males comparing different faith-based attendance practices and different religious preference groups.

REVIEW OF LITERATURE

The Black Faith-Based Organizations and HIV/AIDS

Black faith-based organizations are responding to HIV/AIDS (Cohen, 1999). Prior to the HIV/AIDS pandemic, faith-based organizations often met health and human services needs in black communities (Thomas, Quinn, Billingsley and Caldwell, 1994). One study by Mays and Nicholson (1969) examined 609 urban churches and 185 rural churches and reported that from early in the 19th century these organizations addressed health needs of blacks through programs to feed the poor, free health clinics, recreational activities and child care programs. The Public Health Service eventually used faith-based organizations to mobilize modern health practices among blacks (Thomas et al., 1994). Recent work by black faith-based organizations on HIV/AIDS has raised concerns particularly around drug addiction and homosexuality (Bayer, 1983; Friedman, Southern, Abdul-Quaderr, et al., 1989).

It is estimated that more than half of the black population are church members (Payne, 1991). There are over 30 different black denominations of the Christian religion alone but 88 percent of black faith-based organization members are either Baptists or Methodists (Payne, 1991). Black Christians are located in seven predominantly black denominations. Each has more than one million members. The National Baptist Convention, U.S.A. claims 7.5 million members among 30,000 churches. The National Baptist Convention of America claimed 3.5 million members in 1991; The National Missionary Baptist Convention

of America claimed 3.2 million; and the Progressive National Baptist Convention claimed 1.2 million (Pinkney, 2000). Three Methodist denominations also report having over one million members: the African Methodist Episcopal Church claimed 3.5 million; the African Methodist Episcopal Zion Church claimed 1.2 million; and the Christian Methodist Episcopal church, 1 million (Pinkney, 2000). In addition to this church membership, there are also mosques and storefront churches that attract a large number of blacks.

A survey by the Black Church Family Project confirmed that black faith-based organizations are involved with welfare services (Thomas et al., 1994). Of the faith-based organizations surveyed, 67 percent have at least one community outreach program, 54 percent manage two or more programs and 41 percent operate three or more. Most of these are family support and family assistance programs. They include assistance with clothing, food, and shelter and provide emergency financial aid (Thomas et al., 1994). Few of these programs provide HIV/AIDS education and support services. For example, Rubin, Billingsley and Caldwell (1994) used data from the Black Church Family Project and found that of the 176 churches (28 percent) sponsoring youth programs, only 3 percent were youth AIDS support programs while 2 percent managed youth health-related services (Rubin et al., 1994).

Some faith-based organizations provided leadership to address HIV/AIDS among African Americans. The National Black Leadership Commission on AIDS (BLCA) called for the government to pronounce a national "State of Emergency" on March 3, 1998 (National Black Leadership Commission on AIDS, 1999). BLCA was founded in 1987 with the mission of coordinating, informing, and organizing volunteers among indigenous black leadership including businessmen and women, clergy, elected officials, medical practitioners, media representatives and social policy experts to combat AIDS. One of the major faith-based organizations to work with BLCA was The Balm in Gilead, which is a New York City faith-based organization. Pernessa C. Steele founded The Balm in Gilead in 1989. The organization grew and networked with other private sector organizations in large cities around the country. These organizations lobbied governmental agencies including the CDC for more funds to be channeled to faith-based programs.

Perhaps one of the best statements of the position of faith-based organizations related to HIV/AIDS comes from Reverend Calvin Butts of Abyssinian Baptist Church in Harlem when he said:

> The response of the church is getting better. At one time the church didn't respond and when the church did respond it was negative. Ministers thought that a negative response was in keeping with the thinking that AIDS was transmitted by homosexual transmission, drugs, you know. But as more thoughtful clergy became involved, issues of compassion entered the discussion and we used Jesus' refuge in the house of lepers as an example (Cohen, 1999, p. 286).

The Black Population, Homophobia and HIV/AIDS

In 25 states between January 1994 and June 1997 blacks represented 57 percent of persons 13 years or older with an initial diagnosis of HIV compared to whites that were 34 percent and Hispanics, 7 percent. People with AIDS (PWAs) diagnosis during the same months were 45 percent for both blacks and whites and 8 percent for Hispanics (CDC, 1999). In 36 areas with confidential HIV infection reporting through June 2000, black males between ages 20 and 44 made up 82 percent of the black male HIV infection cases. Among black females, 72 percent of their cases were in females between 20 and 44 years of age (CDC, 2000a).

There has been evidence from several studies that African Americans express greater stigmatization of homosexuality than whites (Rose, 1998). Rose (1998) found in interviews with seropositive black gay men that most black men made good psychological adaptation to their HIV positive status, but it was a result of using tragedy as an opportunity for personal growth. The factors that impeded resolution among black men included black homophobia, difficulties coping with dual identities, traumatic life histories and rejection by black churches. Ernst and his colleagues (1991) presented analyses of gender, educational achievement, religious preference and marital status showing that racial difference in condemnation of homosexuality was derived almost exclusively from a difference in attitude between black and white females.

Ficarrotto (1990) studied racism, sexism, and erotophobia. He found in assessing attitudes toward women, blacks and homosexuals, that emotional erotic conservatism and social prejudice, including racist and sexist beliefs, are independent and equal predictors of anti-homosexual sentiment. Dalton (1989) in earlier days of the epidemic pointed out the alarming statistics on the incidence of AIDS among blacks and the refusal of blacks to acknowledge and take responsibility for the AIDS epidemic as rationally explainable by black self-protection against the stigmas of blame, suspicion, mistrust, homophobia, and il-

licit drug use. Most heterosexuals continue to associate AIDS primarily with bisexuality or homosexuality and these beliefs are correlated with higher levels of antigay attitudes (Herek and Capitanio, 1990).

A study of 190 university students in the southwestern United States showed that African Americans had significantly lower scores on measures of AIDS knowledge and were significantly more homophobic compared to white students (Waldner, Sikka and Baig, 1999). The AIDS pandemic produced an increase in homophobic ideation, feeling and action in the United States (Moss, 1997). The presence of negative attitudes toward homosexuals hampers African American ability to engage in AIDS prevention (Fullilove and Fullilove, 1999). There is evidence indicating that HIV disease progression is more rapid in gay men who are particularly sensitive to social rejection (Cole, Kemeny and Taylor, 1997). Judgmental attitudes toward gay males associated with faith-based organizations may be important detriments to health by creating strained social relationships in environments where care is provided, creating unintended distance between clients and staff and reducing social support.

RESEARCH METHODOLOGY

Do African Americans who regularly attend church have more negative attitudes toward gay males? Are there differences in attitudes among different church attendance practices and religious preferences between black females and males? Are there differences in attitudes among religious preferences? What implications for social workers do these facts have, in light of requests that African American faith-based organizations provide services for persons living with HIV/AIDS?

Sample and Data

The data used for this study were drawn from the National Black Politics Study, 1993. The study was designed to provide information on attitudes and opinions about issues important to black Americans. Respondents provided a set of responses about attitudes toward selected individuals, groups and organizations. They also provided demographic information. The sample (N=1206) universe includes all black households in the United States with telephones. A multiple frame, random-digit probability sample was generated using a national random-digit-dial sample with equal probability of selection. A second frame was randomly selected from a list of households located in census blocks with 50 percent or more black households. All of the analyses here are weighted using census estimates from

March 1994. All replaced missing data were done so by using a linear trend at point estimate. The survey was accomplished between December 1993 and February 1994 and was released in 1998.

Description and Measurement of Variables

First, this study utilized t-tests of attitudes toward gay males by church attendance among African Americans. It then reports analysis of variance that compares mean scores on a measure of attitudes toward gay males by stated religious preferences for all African Americans, males and females. Finally, it reports significant t-tests showing mean differences of the attitude toward gay males score by religious preference for all African Americans, males and females.

The dependent variable is *Attitude Toward Gay Males* (ATGM) and was constructed from the survey item asking respondents to rate certain people and groups on a scale ranging from zero to 100. The scale has not been validated or standardized among diverse populations. The 100-point scale was used in the survey to question attitudes on a variety of individuals and groups. The interviewer stated:

> Now let's talk about your feelings toward political leaders, political groups, and prominent people, who are in the news these days. I'll read the name of a person and I will ask you to rate that person on a thermometer that runs from zero to one-hundred degrees. Ratings between fifty degrees and one-hundred degrees mean that you feel favorable and warm toward that person. Ratings between zero degrees and 50 degrees mean that you don't feel too favorable and are cool toward that person. You may use any number from zero to one-hundred to tell me how favorable your feelings are for each person. Gay men.

The variable was transformed to its logarithm 10 values to improve the estimate. One is interpreted as strongly unfavorable and 100 as strongly favorable.

Church Attendance is respondents' answer to "How often do you attend religious services? Would you say at least once a week, once or twice a month, once or twice a year or never?" The answers were coded as 0 at least once a week; 1 once or twice a month; 2 once or twice a year; 3 never; 8 don't know; 9 refused. Values were recoded as 0 not attending weekly; and 1 attending at least once a week. *Gender* asked "Are you male or female?" Male was coded 0 and female 1. *Religious Preference* was measured by response to the question, "What is your current religion or religious preference?"

RESULTS

The first research question asked if African Americans who regularly attend church have a significantly different attitude toward gay males. Additionally, the question asked if there are differences between females and males. Table 1 compares mean scores on ATGM among all blacks, black females, and black males. It shows that black males who attend church weekly are significantly more negative in their ATGM than black males who do not attend church weekly. This difference did not hold for all blacks and black females. The group of black males who attend church weekly have the lowest mean score (24.0) on ATGM, followed by the mean of black males who do not attend church weekly (29.0). The difference in male ATGM scores was the only significant difference. Males are twice as likely not to attend church at least once each week. Males who attend church weekly tend to score 5 points higher on ATGM than males who do not.

The second research question asked if there are differences in ATGM across different religious preferences and whether or not these differences are gendered. Table 2 presents ANOVA results for all blacks, females and males. The ATGM mean score was significantly different among different religious preferences for all blacks ($F = 2.870$, $p<.05$) and for black males ($F = 3.480$, $p<.01$). Among all blacks, the highest mean score was among Catholic preference (39.1). The lowest mean score was for Islam preference (20). These ranges in mean scores did not hold for female and male groups. For black males, the highest ATGM mean score was for those who had no religious preference (33.3); however, Catholic preference and Others were close with means of 33.2 and 32.3 respectively. The lowest mean for the religious

TABLE 1

T-Tests Comparing Attitude Toward Gay Males by Weekly Church Attendance for All Blacks, Black Females and Black Males

Weekly Church Attendance	N	Odds	Mean	SD	t
All Blacks	463		31.0	27.8	1.630
Not attending weekly	743	1.6	31.0	29.0	
Black Females	289		30.9	28.6	.950
Not attending weekly	377	1.3	33.0	29.3	
Black Males	174		24.0	25.8	2.033*
Not attending weekly	366	2.2	29.0	28.5	

*p< .05

TABLE 2

ANOVA Comparing Attitude Toward Gay Males by Religious Preference for All Blacks, Black Females and Black Males

Religious Preference	N	Mean	SD	95% Confidence	F
All Blacks	1199	30	28.6	28.3, 31.5	2.870*
Protestant	845	29	28	27.1, 30.9	
Catholic	64	39.1	27.8	32.2, 46.1	
Islam	25	20	26.5	9, 31	
None	118	32.4	31.3	26.7, 38.1	
Other	147	30.8	29.5	25.9, 35.6	
Black Females	664	32	29	29.8, 34.3	1.841
Protestant	493	31.6	28.5	29.1, 34.1	
Catholic	35	44.2	32.1	33.1, 55.3	
Islam	7	39.7	34	8.9, 70.4	
None	44	30.8	30	21.7, 40	
Other	86	29.6	28.8	23.4, 35.8	
Black Males	534	27.3	27.9	24.9, 29.6	3.480**
Protestant	352	25.4	26.9	22.6, 28.2	
Catholic	29	33.2	20.6	25.3, 41	
Islam	18	11.9	18.3	2.6, 21.2	
None	74	33.3	32.2	25.8, 40.8	
Other	61	32.3	30.7	24.5, 40.2	

*p< .05 **p< .01

preference groups was Islam (11.9). For black females, the differences among religious preference were not significant. Their mean was 32.

Table 3 presents t-tests of the significant mean differences that compare ATGM between two religious preferences. Catholic preference ATGM score tends to be 10 points higher than Protestant preference for all African Americans. It is nearly 13 points higher for black females, which accounts for the difference between Catholics and Protestants. Among males, ATGM scores for Catholic preference and Islam preference show Islam preference is significantly more negative. For all African Americans, Catholic preference tends to score 19 more points than Islam preference. The males explain the significant difference with 21 more points for Catholic preference males compared to Islam preference males. Catholic preference females tend to score 14 more ATGM points than None preference females and nearly 15 more than Other preference females. Protestant preference males tend to score 13 more ATGM points than Islam males, no preference

TABLE 3

Significant T-Tests of Attitude Towards Gay Males by Religious Preference for All Blacks, Black Females and Black Males

All Blacks (Mean)	N	Mean difference (d)	t
Catholic (39.1) – Protestant (29)	909	10.1 (.35)	2.72**
Catholic (39.1) – Islam (20)	89	19.1 (.66)	2.82**
Black Females			
Catholic (44.2) – Protestant (31.6)	528	12.6 (.43)	2.46*
Catholic (44.2) – None (30.8)	79	13.4 (.46)	2.02*
Catholic (44.2) – Other (29.6)	121	14.6 (.50)	2.49*
Black Males			
Protestant (25.4) – Islam (11.9)	370	13.5 (.48)	1.98*
Catholic (33.2) – Islam (11.9)	47	21.3 (.76)	2.54*
None (33.3) – Protestant (25.4)	426	7.9 (.28)	2.23*
None (33.3) – Islam (11.9)	92	21.4 (.76)	2.91**
Other (32.3) – Islam (11.9)	79	20.4 (.73)	2.72**

*p < .05 **p < .01; Least Significant Difference independent t-tests are presented and differences in means are calculated by subtracting one religious preference mean from another. The d statistic is the standardized mean difference and it is a measure of effect size. $d = (M_1 - M_2)/SD$ where M_1 and M_2 are the comparison means and SD is the pooled standard deviation. The d value of .35 means that the difference between the two average scores is 35% as large as the standard deviation of the outcome measure within each of the religious preference groups.

males tend to score 8 more points than Protestant preference males and no preference males tend to score 21 points higher than Islam preference males. Other preference males tend to score 20 points higher than Islam preference males.

The effects of Catholic preference for females and Islam preference for males reveal that Catholic females have significant more positive attitudes while Islam preference males have significant more negative attitudes reported in these data.

DISCUSSION

Findings of this study confirm differences among groups of African Americans in ATGM scores. These findings have practical application. According to sociologist A. Wade Smith (1993), nationally representative surveys of African Americans were unavailable in any numbers until the 1980s when the Institute for Social Research and the National Opinion Research Center initiated attempts to tap their opinions. But even though a few of these surveys exist, I am unaware of any study that attempts to

report black ATGM in context of religious preferences using a nationally representative sample. The differences among males and females identifying with different religious groups in the present study suggest that allocating social service dollars to organizations possibly needs to include targeted dollars for counseling and education about sexual orientation. There is a distinction between faith-based leadership and faith-based communities. It may be more prudent to organize educational campaigns directed at the black clergy around HIV/AIDS transmission and specific ways of transmission among African Americans. The hope for such a method is that faith-based leadership will provide counseling and education to the larger faith-based community.

An additional finding in this study is respondents with Catholic preference had higher ATGM scores. This is particularly the case among black females. The Catholic Church officials have consistently rejected claims by gay activists for recognition in terms of the AIDS pandemic (*Advocate*, 2001). The George W. Bush administration ignored this conflict when it attempted to expand support for his faith-based initiative by honoring "Roman Catholic organizations for their work in helping low-income families, the homeless, the elderly and people living with AIDS" (Browne, 2001). In fact, Housing Secretary Mel Martinez noted the work Catholic Charities had done specifically with HIV/AIDS persons and remarked, "I know from personal experience what faith-based groups can do." This occurred one week after the Bush administration had created the White House Office for Faith-Based and Community Initiatives and directed five government agencies to establish their own respective offices within 45 days (Browne, 2001).

By February 2002, the faith based initiative changed in details but in effect the consequences largely remained the same. For example the Salvation Army had lobbied the White House to back measures that would not block its right to discriminate against hiring gays while receiving federal funds (Roth, 2002). This attempt was defeated. In that process, President Bush appointed Jim Towny as the head the Faith Based Initiative after the resignation of John J. Dilulio, Jr. A consensus emerged including charitable tax deductions for filers who do not itemize, requiring faith-based organizations to set up separate operations to handle their social services, and encouraging private-sector donations to faith-based groups (Peterson, 2002).

A number of studies have recently focused not only on health and religious preference but health and spirituality (Canda, 1989; Lewandowski and Canda, 1995; Remele, 2001).

Religiosity, religious preference and spirituality are distinctive dimensions of health and health social service. It has become clear there is an instrumental role for faith-based organizations working with PWAs to play given the importance of religiosity, religious preference and spirituality among PWAs (Demi, Moneyham, Sowell and Cohen, 1997; Roberts, 1995; Siegel and Schrimshaw, 2000). This study corroborates other studies interested in religiosity, religious preference and spirituality associated with attitudes toward gay males and its implications for HIV/AIDS services. Faith-based attitudes and organizations are related to the provision of health and well-being. Chambré (2001) reported that congregational membership, attendance at religious services and levels of volunteering and charitable giving are highly correlated.

There appears to be real differences between males and females and their ATGM scores. Ernst and his colleagues (1991) reported most homophobia among African Americans in females. Findings in this study point to differences between females and males. For one thing, there are differences between females and males where males have lower ATGM scores in the aggregate. Second, there are differences among groups of females as well as groups of males. These observations directly contrast with the Ernst study.

The Congressional Black Caucus first asked the Clinton administration to declare a state of emergency over HIV in 1998 and at that time received $156 million. In 1999, the amount increased to $245 million, in 2000, $350 million and in 2001, $540 million (Staples, 2001). These funds are allocated as block grants to states that distribute them to various groups. In addition, some faith-based organizations would modify their sectarian values in the provision of social services to PWAs by assuming more secular approaches to service delivery (Chambré, 2001). At this point we do not have data on the proportion of allocated HIV/AIDS funds being sought by or allocated to faith-based organizations. These allocations will be handled differently given the 2002 Faith-Based Initiative consensus.

Additional variables not included in this study are necessary to fully understand the influence of religious preferences on ATGM scores. These culturally and historically based attitudes must be understood as part of the shared knowledge base of communities working to combat HIV/AIDS. For example, multivariate analyses might look at income, education and age to see if among various religious groups these variables are significant. It might be that religious preference groups' education, family structure, norms and social class will influence attitudes. Another

limitation of these data is the sample size and the ATGM item construction. If the sample size had been larger, it might have been possible to compare religious denominations rather than preferences. Measures of denominational affiliation would be helpful in future research. A standardized measure of ATGM would prove to be a more powerful measure. Unfortunately, to date we have no standardized and validated measure of black homophobia.

IMPLICATIONS FOR APPLIED SOCIOLOGY AND SOCIAL WORK

Results of this study are evidence that among African Americans gender and religious preference report different ATGM scores. The special needs of gay males related to HIV/AIDS raise a concern about advocating for policies that channel dollars to faith-based organizations to do HIV/AIDS social services. Is it likely that organizations with negative or judgmental attitudes toward clients will be capable of providing them healthy social services? The grand result of such faith-based strategies might be to direct limited resources from other AIDS services organizations to faith-based organizations that share an antipathy toward gay males. This area of research has been neglected but its importance for applied sociology, social work, and social welfare policy is unambiguous. The findings have implications for educating providers of social services in HIV/AIDS programs about the specific developmental needs of black faith-based institutions' knowledge base around issues of human sexuality. Applied sociologists and social workers in faith-based settings working with African Americans are in a distinctive position to develop strategies to sensitize faith-based participants about discrimination, prejudice, and stigma they might harbor against gay males, particularly against those groups often thought to be responsible for their own conditions like many homosexual PWAs are thought to be responsible for their illnesses.

Applied sociologists and social workers in the field that come in contact with clients who are HIV positive gay males will find implications from the results of this study. It might be necessary to play more of an educative role before referring gay clients, both HIV affected and infected, to faith-based social services. It is important to bridge this space between gay males and African American communities particularly in terms of the new chronic nature of HIV infection, where social services must be provided for marginalized and stigmatized sectors of the population for a greater length of time. Increasingly the management of HIV/AIDS—and to some extent Hepatitis C—will require that social workers target infectious disease service providers and

referrals to community-based service organizations, including faith-based organizations and their social services organizations. The trend has now become to shift the burden of care from governmental agencies to the community, and this is a complicated issue in light of the reality that women are usually the caregivers in the informal care sector of society. The tendency to shift caregiving to the informal sector can be seen to mask gender inequality in society as grandmothers, aunts and sisters become responsible for caring for the ill and the orphaned that result from AIDS parental deaths (Lemelle and Harrington, 1998). Proposals to increasingly employ faith-based contributions to service centers that are presumably controlled and sometimes managed by males, along with everyday gender and sexual orientation inequality and female and male attitudes toward various stigmatized groups raises the stakes for evaluating and measuring conduct to reduce stigma. Applied sociologists and social workers will increasingly be needed to provide sensitizing education on these fronts.

References

Advocate. (2001). No blessing from the Vatican. *Advocate,* Feb. 13, 16.

Bayer, R. (1993). *Private acts, social consequences: AIDS and the politics of public health.* New Brunswick: Rutgers University Press.

Browne, J.Z. (2001). Bush extend financial, moral support in honoring Roman Catholic organizations. *New York Amsterdam News,* 92(6), 40.

Canda, E.R. (1989). Religious content in social work education: A comparative approach. *Journal of Social Work Education,* 25(1), 36–45.

CDC. (1999). CDC guidelines for national human immunodeficiency virus case surveillance, including monitoring for human immunodeficiency virus infection and acquired immunodeficiency syndrome. *Morbidity and Mortality Weekly Report,* 10(48).

CDC. (2000a). *HIV/AIDS surveillance report* 12(1).

CDC. (2000b). HIV prevention strategic plan through 2005, draft, September 2000. *Center for Disease Control and Prevention,* 16.

Chambré, S.M. (2001). The changing nature of "faith" in faith-based organizations: Secularization and ecumenicism in four AIDS organizations in New York City. *Social Service Review,* 75(3), 435–455.

Cohen, C.J. (1999). *The boundaries of blackness: AIDS and the breakdown of black politics.* Chicago: University of Chicago Press.

Cole, S.W., Kemeny, M.E. & Taylor S.E. (1997). Social identity and physical health: accelerated HIV progression in rejection-sensitive gay men. *Journal of Personality & Social Psychology,* 72(2), 320–35.

Cone, J.H. (1989). Black theology and liberation theology. In G.S. Wilmore (Ed.), *African American religious studies* (pp. 177–207). Durham: Duke University Press.

Dalton, H. (1989). AIDS in blackface. *Daedalus,* 118(3), 205–27.

Dawson, M., Brown, R. & Jackson, J. S. (1998). *National black politics study, 1993* [computer file]. Ann Arbor, MI: Inter-university Consortium for Political and Social Research.

Demi, A., Moneyham, L., Sowell, R. & Cohen, L. (1997). Coping strategies used by HIV infected women. *Omega,* 35(4), 377–391.

Ernst, F.A., Francis, R.A., Nevels, H. Lemeh, C.A. (1991). Condemnation of homosexuality in the black community: A gender-specific phenomenon? *Archives of Sexual Behavior,* 20(6), 579–585.

Ficarrotto, T.J. (1990). Racism, sexism, and erotophobia: Attitudes of heterosexuals toward homosexuals. *Journal of Homosexuality,* 19(1), 111–16.

Friedman, S.R., Sotheran, J.L., Abdul-Quaderr, A., Primm, P.J., Des Jarlais, D.C., Kleinman, P. Mauge, C., Goldsmith, D.S., El-Sadr, W. & Maslansky, R. (1989). The AIDS epidemic among blacks and Hispanics. In D.P. Willis (Ed.), *Health policies and black Americans* (pp. 455–99). New Brunswick: Transaction.

Fullilove, M.T. & Fullilove, R.E. (1996). The peculiar epidemic, part II: African American clergy grapple with AIDS. Unpublished manuscript.

Fullilove, M.T. & Fullilove, R.E. (1999). Stigma as an obstacle to AIDS action: The case of the African American community. *American Behavioral Scientist,* 42(7), 1117–29.

Henderson, C.W. (2000). Black church leaders meet to plan AIDS strategies. *AIDS Weekly,* 6/12–6/18, 11.

Herek, G.M. & Capitanio, J.P. (1999). AIDS stigma and sexual preference. *American Behavioral Scientist,* 42(7), 1130–47.

Human Rights Watch. (2001). *No escape: Male rape in U.S. prisons.* New York: Human Rights Watch Press.

King, M.L. (1958). *Stride toward freedom.* New York: Harper & Row.

Kirkham, G.L. (2000). Homosexuality in prison. In P.C.R. Rust (Ed.), *Bisexuality in the United States* (pp. 250–266). New York: Columbia University Press.

Lemelle, A.J. & Harrington, C. (1998). The political economy of caregiving for people with HIV/AIDS. In M. Singer (Ed.), *The political economy of AIDS* (pp. 149–66). Amityville, NY: Baywood Press.

Lewandowski, C.A. & Canda, E.R. (1995). A typological model for assessment of religious groups. *Social Thought,* 18, 1, pp. 17–38.

Marable, M. (1989). Religion and black protest thought in African American history. In G.S. Wilmore (Ed.), *African American religious studies* (pp. 318–39). Durham: Duke University Press.

Mays, B. & Nicholson J. (1969). *The Negro's church.* New York: Russell and Russell.

Morales, E.S. & Fullilove, M.T. (1992). "Many are called . . . ": Participation by minority leaders in an AIDS intervention in San Francisco. *Ethnicity and Disease,* 2, 389–401.

Morris, A.D. (1984). *The origins of the civil rights movement: Black communities organizing for change.* New York: The Free Press.

Moss, E. (1997). On situating homophobia. *Journal of the American Psychoanalytic Association,* 45(1), 1201–215.

Myrdal, G. (1944). *An American dilemma: The Negro problem and modern democracy.* New York: Harper & Brothers.

National Black Leadership Commission on AIDS. (1999). *HIV/AIDS and public health African Americans in crisis: A national state of emergency.* Xeroxed report October 25.

Payne, W.J. (1991). *Directory of African American religious bodies.* Washington D.C.: Howard University Press.

Peterson, Jonathan. (2002). Faith-Based initiative gains unusual leader. *Los Angeles Times,* Feb. 2, 12.

Pinkney, A. (2000). *Black Americans.* Upper Saddle River, NJ: Prentice Hall.

Remle, R.C. (2001). Religion and spirituality in HIV/AIDS communities: A literature review. Paper presented at the Southern Sociological Society meeting.

Roberts, T.L. (1995). African American gay males with HIV/AIDS: Building upon cultural capacities to survive. *Journal of Gay & Lesbian Social Services,* 2(3–4), 75–87.

Rose, S. (1998). Searching for the meaning of AIDS: Issues affecting seropositive black gay men. In V.J. Derlega & A.P. Barbee (Eds.), *HIV and social interaction* (pp. 56–82). Thousand Oaks, CA: Sage.

Roth, Bennett. (2002). Faith-Based effort gains ground: most controversial issues not included in bid to help charities. *The Houston Chronicle*, Feb. 8, 3.

Rubin, R.H., Billingsley, A. & Caldwell, C.H. (1994). The role of the black church in working with black adolescents. *Adolescence,* 29(114), 251–66.

Rust, P.C.R. (2000). Bisexuality in HIV research. In P.C.R. Rust (Ed.), *Bisexuality in the United States* (pp. 355–399). New York: Columbia University Press.

Siegel, K. & Schrimshaw, E.W. (2000). Perceiving benefits in adversity: Stress-related growth in women living with HIV/AIDS. *Social Science & Medicine*, 51(10), 1543–1554.

Smith, A.W. (1993). Survey research on African Americans. In J.H. Stanfield & R.M. Dennis (Eds.), *Race and ethnicity in research methods* (pp. 217–229). Newbury Park, CA: Sage.

Staples, G.B. (2001). Black leaders urge AIDS war. *The Atlanta Journal and Constitution,* June 9, 3A.

Thomas, S.B., Quinn S.C., Billingsley, A. & Caldwell, C. (1994). The characteristics of northern black churches with community health outreach programs. *American Journal of Public Health,* 84(4), 575–79.

Waldner, L.K., Sikka A. & Baig, S. (1999). Ethnicity and sex differences in university students' knowledge of AIDS, fear of AIDS, and homophobia. *Journal of Homosexuality,* 37(3), 117–133.

Weinstein, M. (1990). Add AIDS to the list. Unpublished master's thesis, San Francisco State University.