

HOMOPHOBIA AND HIV TRANSMISSION:
A SIX-COUNTRY COMPARATIVE ANALYSIS

by

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Abstract

This interdisciplinary study combines epidemiological data with anthropological theory to investigate the relationship between HIV transmission rates and systemic homophobia.

Previous research has illustrated the link between high levels of *structural violence* and *structural stigma* to increased risk of diseases such as the link between African-Americans and heart disease. This study investigates the relationship between systemic homophobia and HIV transmission rates. Through *operationalizing* homophobia into seven distinct factors, I evaluated systemic homophobia in six countries, assigning a score 1-10 to each factor using secondary source aggregation. I compared composite scores, as well as scores in each operationalized factor to HIV transmission rates in those countries. The results of this study indicate a correlation between systemic homophobia and increased HIV transmission, particularly in respect to the factors Marriage Equality, LGBT Laws, Religiosity, LGBT Visibility, and Hate Crimes. Though various sociocultural factors play a role in HIV transmission, this study indicates that homophobia plays an integral role in HIV transmission. This project has pertinent applications in epidemiology, anthropology and public health illustrating the integral role of sociocultural and systemic factors that increase structural violence and risk for a disease.

Dedication

To Dr. Bill Safranek, thank you for picking up a project outside of your range of expertise and allowing me to pursue a project I loved. Your presence in my committee has been missed but your impact never forgotten.

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To Mom and Dad, thank you for your unending love and support to pursue my dreams wholeheartedly.

To LGBT people around the world, may this research and research like it bring increased freedom, equality, and protections such that we may one day be safer, healthier, and more equal members of society.

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List of Acronyms

AIDS Acquired Immune Deficiency Syndrome

AMA American Medical Association

APA American Psychological Association

ART Antiretroviral Therapy

ART Assisted Reproductive Technology

HIV Human Immunodeficiency Virus

IDU Intravenous Drug Users

LGBT Lesbian, Gay, Bisexual, and Transgender

MSM Men who have Sex with Men

NGO Non-Governmental Organization

INTRODUCTION

The global epidemic of HIV throughout the past four decades has established the need to investigate the reasons for its rapid transmission. Misunderstandings, social stigma, and blatant homophobia have contributed to the social construction of the disease. The early emphasis on transmission in homosexual population in a homophobic atmosphere created a social stigma surrounding the disease that has persisted to today. The emphasis on identifying risk groups, such as MSM and IDU has helped to limit the spread of the disease; however, current transmission of HIV is still increasing in a number of countries and populations outside of the traditionally recognized risk groups are experiencing large spikes in HIV incidence. Structural violence, as defined later in the thesis, constructs limitations in access and quality of healthcare. I propose, therefore, that systemic homophobia is a form of structural violence that influences the transmission of HIV. Medical anthropologists and social epidemiologists continue to study the ways in which disease and society interact, the influences of stigma, and the sociocultural and economic factors that contribute to disease spread. This project investigates the correlation between the social influence of systemic homophobia and HIV transmission. I hypothesize a correlation between systemic homophobia, as operationalized into seven distinct factors, and increased HIV transmission. Through secondary source aggregation, I scored six countries in seven factors and compared composite and individual scores to HIV transmission rates.

BACKGROUND AND LITERATURE REVIEW

In 2013, the Supreme Court made a groundbreaking 5-4 decision in the *United States v. Windsor* case to repeal the 1996 Defense of Marriage Act that made it federal law to interpret “marriage” and “spouse” as strictly referring to heterosexual unions. This historic decision was a major victory in the struggle for the recognition of same-sex marriage. In the last decade, a number of states have implemented their own progressive same-sex marriage rights before the Supreme Court’s decision in the Windsor case; however the court’s ruling was a further impetus to move legislature in this direction. In fact, over the course of the 12 months since the decision was released, 15 additional states have struck down state marriage bans bringing the United States up to a total of 19 states that issue same-sex marriage licenses. Thirteen additional states recognize same-sex marriage and are currently undergoing the processes to successfully administer licenses. This dramatic expansion of same-sex marriage rights in the US has significantly increased the exposure to and awareness of marriage equality issues and the plight of the gay, lesbian, bisexual, and transgendered (LGBT) communities. Such rulings also contribute to the normalization of same-sex rights as legitimate claims for civil, political¹, and human rights.

Elsewhere in the world, scholars and the media are observing a different trend. For example, both Uganda and Russia have pushed to criminalize LGBT people and same-sex relationships. In early 2014, the president of Uganda signed into law a bill that criminalized

¹ Civil rights are those that relate to individuals and matters of privacy, particularly in the realm of race, gender and sexual orientation (Marshall 1995). These include freedom of speech, protection from discrimination and violence. Political rights refer to procedural fairness and grant rights such as the right to vote, the right to due process and the right to assemble (Turner 1993). Human rights are more abstract and describe the inalienable rights such as the right to freedom and the freedom to pursue happiness.

same-sex behavior, punishable with life in prison (Clark 2014). The bill was hotly debated, particularly on a national level, primarily because early drafts considered the death penalty a viable punishment. Ultimately the death clause was dropped; however, LGBT people continue to face persecution and face life in prison (Clark 2014). While Russia has yet to criminalize LGBT populations, the introduction of a bill signed into law in the summer of 2013 criminalized what the government loosely defined as “LGBT propaganda” (Amirkhanian 2014). The sentiment at the time was pushing towards reducing LGBT rights and increasing legislation that would ultimately bar LGBT people from being full citizens.

An interesting question that emerges from this varied political and sociocultural landscape is: How does this movement towards greater or lesser equality of rights impact the health and well-being of LGBT individuals and communities? Undoubtedly experiences of the LGBT individuals and communities under various progressive or regressive policies and attitudes can be dramatically different. While the US rulings have the potential of increasing tolerance and acceptance toward the LGBT groups, changing sociocultural attitudes that marginalize particular groups based on race, class, sexual orientation, gender expression or other line of division are likely to move at a much slower pace. An analysis of the history of medicine and law reveals that the two movements toward human rights and health rights have often been understood as separate areas of scholarship, despite the fact that, as Stephen P. Marks, a public health and legal scholar, argues, “both spring from an ancient and basic human need, a need for justice in the case of human rights, and for physical and mental well-being in the case of health (Marks 2002:739). Likewise, while LGBT rights and health have been analyzed as separate lines

of inquiry in social science and public health scholarship, the *relationship* between the status of same-sex human rights and the health of this population has largely been understudied.

The systematic oppression of a group of people is often linked with increased incidence and prevalence of specific diseases (Marks 2002). In the case of the LGBT population, the historic link is largely associated with sexually transmitted infections, particularly human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). HIV is the biological etiology behind AIDS². The virus can be contracted by three mechanisms: sexual transmission through body fluids, contact with blood (intravenous drug use, hospital acquired HIV) or vertical transmission from parent to child.

A significant barrier in understanding HIV transmission and prevention has been the lack of sex education or inadequate and inconsistent sex education in schools (Alford 2003, Schwartz 1996, Welbourne 1989, McManus 2008). However an equally significant driver of new infections has been the cultural construction of AIDS as a “gay disease” (Seigel 1998, Zita 2002). In fact, in 1985 during the early years of the epidemic, *Discover* magazine published a cover report with what was pitched as scientific facts explaining that “[c]ontrary to what you

² Once in the body, the virus operates by infecting cells of the immune system, primarily CD4 T cells. As cells become infected, CD8 T cells kill off infected cells, thereby drastically decreasing the number of CD4 cells in the body (Marks 2002). Cell mediated immunity can be lost through the destruction of CD4 cells thereby seriously compromising or destroying the body’s immune system, leaving the individual vulnerable to a number of opportunistic infections, including pneumonia, influenza, tuberculosis, and cytomegalovirus. Virulent pathogens like TB thereby become even more dangerous; bacteria that would typically be readily removed by a healthy immune system become difficult to fight, easily infecting the body (Finkelstein 1996). The body also becomes host to opportunistic infections. Bacteria that do not normally cause disease may cause severe infections (Finkelstein 1996, Bentwich 2000). HIV is a retrovirus, a classification that indicates that it contains single stranded RNA as its nucleic acid (Kumar 2012). The nucleic acid contains nine genes that control the virus’s ability to infect and ultimately replicate. HIV requires the enzyme reverse transcriptase in order to incorporate its genetic information into the host’s genome (Weiss 1993). By incorporating its genome, it is able to use the machinery of the infected cell in order to build proteins and the parts necessary to replicate itself. The HIV virology is relevant in the context of the increased risk in LGBT populations, and will therefore be discussed further later in this thesis (Weiss 1993).

heard, AIDS is not a threat to the vast majority of heterosexuals or a peril to humanity. It is—and is likely to remain—largely the fatal price one can pay for anal intercourse” (*Discover* 1985: p. 36). In 2005, *Discover* published a follow up article titled, “20 Years ago in Discover: Misunderstanding AIDS” highlighting how data for the 1985 report was collected from leading American, British, and French epidemiologists and publications in the *Journal of the American Medical Association* and the *Lancet*, and how the scientific thinking was skewed by a cultural bias against homosexuality (Casselmann 2005:1).

Despite the new evidence-based understanding of AIDS that emerged since the 1980s, including measurable increases in infection rates for heterosexual populations, HIV is still largely associated with gay men, and the associated stigma persists (Seigel 1998, Jeffries 2015). The perception that HIV mainly affects gay men has, in many ways, helped to facilitate the transmission of the disease to other populations (Friedman 2014). Studies indicate that bisexual men have contributed to the spread of the disease to men and women. Specifically, research shows that bisexual men who have sex with men (MSM) are not always aware that they can spread the virus to women (Zule 2009). In addition to inadequate knowledge, risky behavior is also linked to local cultural factors. For example, the cultural construction of sexuality in Brazil dictates that bisexual men who are the active partner in an encounter with another man, do not think of themselves as “gay” (Goldstein 1994). MSM in Brazil only consider themselves “gay” if they are the passive partner; active partners exclude themselves from the LGBT community. Early HIV prevention programs that were generally successful in North America and Europe failed to stop the HIV epidemic in Brazil because most of these programs targeted “gay men” (Goldstein 1994). This cultural construct increases risk because the men who engage in risky

behavior do not consider themselves to be at risk, and thus do not identify with the prevention program methods. Active partners then may contract HIV and then pass it to several women. Cultural specification such as this led to the development of the terms “MSM” and “MSMW” which extends coverage to this at risk population without labeling a man “gay” or “bisexual.” The term MSM attempts to address culturally diverse phenomena related to HIV spread without traditional labels.

The differences in the cultural construction of sexuality are not unique to Brazil. In the United States, bisexual men and men on the “down low”³ created a similar gap in the prevention programs. The active partners likewise believed they could not become infected nor transmit it to women. This lack of education led to bisexual men and men on the “down low” becoming infected and transmitting the disease to both men and women (Friedman 2014, Barnshaw 2010, Zule 2009).

Another common misconception within the LGBT population that contributes to HIV transmission is that only the receiving or passive partner can become infected with HIV (Zule 2009). This is complicated further by bisexual men whose behavior can have a far reaching potential for transmission in that HIV negative men, who might be MSMW, act as the active partner with an HIV positive passive partner, acquire HIV, and transmit it to women (Barnshaw 2010). The MSM population, however, remains the highest prevalence group and is considered

³ The term “down low” originated in the southern United States among African American males who fell into one of three categories: (1) Bisexual males who were open about their relationships with women but hid encounters with men; (2) Homosexual males who did not have encounters with women but were not open about their homosexuality; and (3) Men who identified as heterosexual but fell into the MSM category. The term is widely used in the research community to refer to African American MSM, but has since been absorbed by the gay and bisexual community in general to indicate anyone who is hiding their orientation or sexual encounters with the same-sex.

by various epidemiological studies as the highest risk group for the disease.⁴ While the categorization of risk groups may not be the best way to monitor and prevent diseases and HIV transmission to all other segments of the population has been recorded, the epidemiological data clearly indicates that MSM continue to suffer the highest rates of HIV infection.

While the field of epidemiology is admittedly complex, HIV has proven to be incredibly difficult to track and prevent due to behavioral complexities as well as the effects of stigma. Many scholars believe that the link with the MSM population is two-fold. Firstly, the inadequate education about sex between people of the same-sex was one of the original reasons that HIV spread so rapidly within the GBT MSM community in the late 1970s and early 1980s (Friedman 2014, Zita 2002). The absence of a risk of pregnancy in same-sex relationships was enough to make condom use seem unnecessary, and promoted increased sexual activity and number of partners in this group (Zita 2002).⁵ These complexities in both behaviors and perceptions, and the associated challenges of monitoring this infection, have contributed to HIV spreading rapidly within the community, particularly before it was even identified as a disease in the 1980s. Secondly, the role of stigma against LGBT individuals is a critical element in the HIV transmission. The marginalization and associated decreased visibility of LGBT populations blocks accurate and precise data collection. Many LGBT individuals hide their identity in employment, school, certain social settings, and even when seeking health care. Concealing

⁴ Statistics from the Center for Disease Control and Prevention and the World Health Organization indicate that MSM are at a higher risk for HIV both within the United States and globally. The CDC reports that MSM comprise 63% of incident cases of HIV in the United States.

⁵ While nonmonogamous relationships and multiple partners are behaviors and arrangements present in all sexually active populations, these practices have been more prevalent among same-sex couples, in particular men (Shernoff 2006)

sexual identity and/or particular sexual behaviors has been particularly prevalent amongst MSMW (Schrimshaw 2013).

The roots of stigma can be traced to the early period of the epidemic when many in the conservative segments of the society and the right-leaning media initially claimed that HIV was “gay cancer” and many hailed it as God’s punishment for a perceived sin, (*Body Politic* 1983:17) thereby promoting stigma against the GBT individuals in need of treatment and support. While these claims have largely decreased in recent years, they prevailed throughout the late 1990s and are still continuing in some segments of the populations due, in part, to inadequate education and often times, deliberate bigotry.

Theoretical Framework

This project, as an interdisciplinary study, requires a theoretical framework which relies on concepts and theories developed in medical anthropology and other social sciences, which will help frame the question of the relationship between the status of same-sex human rights and the health of this population. The three key theoretical frameworks that guide this project are: (1) structural violence (Farmer 2009), (2) “risk” as an epidemiological and cultural construct (Glick-Schiller 1994), and (3) structural stigma (Hatzenbuehler 2014). These theoretical frameworks are useful in analyzing factors that put certain populations at higher risk for disease. Rather than identifying those who are at a higher risk, these concepts and associated analytical approaches instead place emphasis on the cultural, socioeconomic, and political factors underlying health risks and health risk categories, and focus on why and to what extent these risks can, or cannot be minimized or managed. In the following discussion, I highlight how each of these frameworks

is relevant to the question of the relationship between the rights and experiences of LGBT populations and HIV infection epidemiology.

Structural Violence and Health

Medical anthropologist and physician, Paul Farmer,⁶ developed⁷ the term “structural violence” to explain and highlight the ways in which socioeconomic, public policy, and other structural factors shape access and quality of healthcare services. Farmer demonstrates that structural violence takes shape in any political, economic, or social policy that perpetuates risk through denying a population “access to the fruits of scientific and social progress” (Farmer 2003). Structural violence is thus any social arrangement that puts an individual or population in harm’s way (Farmer 2006). Farmer describes these social arrangements in terms of axes of oppression. These axes include the axis of gender, the axis of race, and the axis of poverty (Farmer 2003). Farmer also indicates that other axes of oppression may exist, defined as those elements of society that limit equal access to scientific progress and in most cases, quality healthcare thereby creating a system of exclusion that influences disease status, treatment, and lifespan (Farmer 2003). Farmer suggests that “homophobia may be said to hasten the development of AIDS if it denies services to those already infected with HIV” (Farmer 2003, p.

⁶ Paul Farmer is a physician with a Ph.D. in Medical Anthropology who has worked extensively to increase access to health care services in Haiti. His ethnographic research in AIDS in Haiti showed how cultural constructions of blame, in particular as related to sorcery, have been significant in the spread of HIV. Furthermore, he has published extensively on the multiple forms of structural constraints within the healthcare system in Haiti, the US and other settings, including the recent Ebola epidemic in Africa. In his work he focuses primarily on poverty and race and the ways that public policies and cultural systems take a form of violence against a group of people. He is the founder of Partners in Health, a nongovernmental organization that works “to bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair” (Partners in Health, See <http://www.pih.org/pages/our-mission> . Accessed: January 2015).

⁷ The term *structural violence* was originally coined by sociologist Johan Galtung in his publication *Violence, Peace, and Peace Research* (1967) in order to expand the definition of violence. His emphasis focused on the definitions of peace and how violence, in different forms, violated peace. Paul Farmer expanded this term to focus on social inequalities (2003, 2008).

46). I therefore propose the existence of a fourth axis, the axis of homophobia, that I will argue directly influences HIV transmission rates by establishing a system of violence against LGBT people.

Farmer, who has largely dedicated his life to increasing access to HIV healthcare, particularly in Haiti, argues that to understand why situations such as the AIDS epidemic in Haiti occur, one must have a “thorough knowledge of history and political economy” (Farmer 2001:page 305). Only with this knowledge can one understand the ways in which social and economic policy perpetuates health-related risks in Haiti. The history and policy in Haiti have constructed a structure of violence that harms people in the form of HIV and AIDS. The poor, who have limited access to health insurance and thus quality healthcare, largely populate the country. Much of the population lives too far away from clinics and has no efficient means of getting there, thus otherwise treatable diseases are prevalent. Specifically, the majority of Haitians have no access to treatment for HIV. This is particularly relevant in the case of HIV positive pregnant women in which the Haitian system limits the access to proper treatments to prevent spread of the virus to the fetus. Farmer is careful to note that neither individual nor society is at fault, rather, a longstanding history of social and public policy has structured a system against specific populations (Farmer 2004). Structural violence shows that a systemic, pervasive, and lasting force plays a large role in the differential access to healthcare wherein some populations have greater access and receive higher quality of care than others. In Haiti, the devastating rates of poverty limit access to healthcare. Those near clinics cannot pay for healthcare and there are very few clinics and physicians in general. In the rural areas, Haitians are too far from clinics and cannot pay to travel. With an emphasis on socioeconomic status of

certain groups, particularly the country of Haiti, Farmer has shown that government and social policies put specific populations not only at increased risk for disease, but also at decreased access to health services. Political violence in the country has impoverished the nation; human decisions to spend on war and political turmoil have contributed to the poverty in the nation (Farmer 2009; p. 12). Poverty is a form of structural violence; the poor have less access to quality education, in particular quality health and sex education. Access to condoms and sexual health literature is limited. While the reasons for this increased risk are also linked to religion and complex cultural beliefs,⁸ a lack of access to quality education increases risks on the poor that could otherwise be mitigated through better knowledge of how transmission of infection works and how to prevent it. These sociocultural and economic forces as well as racial disparities, which are also linked to socioeconomic status, were among the largest contributors to HIV transmission (Adler 2006, Ickovicks 2002, McNair 2004, Thomas 1999). Racial disparities have also been identified in the areas of access to education, condoms, and quality healthcare. These factors increase HIV transmission rates in poverty stricken areas. Identifying structural forces behind increased health risk and continued health disparities is highly significant as a way to bring attention to potential public policy solutions. Scholarship on social inequalities has been particularly important in providing evidence and informing public policy changes to increase quality and access to healthcare.

For example, epidemiological studies have shown that African American populations in the US are at higher risk for heart disease (Jones 2010). Social science and public health scholars

⁸ Religious or cultural convictions that sex is taboo shape perceptions in how information and education regarding sex should be disseminated, if at all. For example, the Catholic Church adamantly opposes any form of sex education other than abstinence-only programs, while Japanese cultural convictions strongly hold sex as taboo, without any religious grounds.

have subsequently exposed this increased risk as a product of key structural causes. In particular, African American populations tend to have decreased access to proper nutrition and often lack healthier options for food. Healthy food is often more expensive and access to fresh and quality foods is therefore stratified by income (Larsen 2009). Recently, scholars have identified the emergence of “food deserts”—geographic areas in the US that are devoid of fresh grocery stores with fresh produce. Food deserts are most often found in impoverished and urbanized areas, therefore creating a structural limitation on healthy eating. Therefore, structural causes that include a combination of low income and difficult access to stores with nutritious foods are more decisive in increasing risks for the diseases such as type II diabetes than individual choice to eat “poorly.”

Likewise, applying the analytical framework of structural violence is useful in the examination of HIV and LGBT experiences and related policies. While the link between HIV and MSM is well established as indicated by the Center for Disease Control and Prevention, this thesis focuses instead on the underlying structural factors that impose social suffering and perpetuate marginalization of these populations, thereby, as I argue, facilitating increased risk and transmission of HIV in this population.

Conceptualizations of “Risk” in the Context of Health

The second theoretical concept useful in contextualizing this study is the concept of risk and how risk has been understood. Epidemiologists and public health researchers have largely emphasized the importance of identifying risk *groups* to help study a disease. By identifying risk groups, interventions programs developed by epidemiologists and physicians can more efficiently focus time and money on the groups who are at higher risk for the disease. Rather

than a widespread population-based approach, epidemiologists can instead focus on narrow groups and push interventional medicine where it might be needed. A significant limitation of risk group identification is the conceptualization of a lack of risk for those outside the risk group. For example, efforts to prevent HIV first focused on gay men as rates in gay men were particularly high. However, MSM do not always identify as gay such as in the aforementioned case in Brazil (Goldstein 1994). Targeting risk groups can therefore be limited by how people self-identify as “at risk.”

While the concept of risk groups is still widely applied in the field of epidemiology, identification of HIV risk groups has been shown to overlook the true causation of the problem, namely the behavior itself (Glick Schiller 1994). For example, only recently have HIV prevention education programs shifted to focus on the behavior of engaging in unprotected sex with an infected individual as risky, rather than targeting people whom self-identify as gay or homosexual. In addition to its limited usefulness in HIV prevention, the construct of risk groups has also culturally stigmatized those with HIV into one of two categories: gay or bisexual men or intravenous drug users. In reality, HIV’s molecular mode of transmission does not target either of these two groups. HIV has the capacity to and does infect anyone. The categorization of HIV risk groups has stigmatized the disease as a disease that affects categories of people who in the past have been perceived as “socially deviant,” including gays, sex workers, and drug users.

Anthropologists have argued that to reduce the stigma and create more effective health care interventions, the focus should be shifted to help eliminate the behaviors and decisions that put these specific groups at risk. Furthermore, most recently the shift has been to focus on *risk situations*. Social scientists argue that certain cultural situations that are out of the control of the

person at risk, perpetuates risk for disease. For example, Ida Susser, a prominent anthropologist studying HIV in Africa found that risk situations play a prominent role in HIV transmission (Susser 2010). Specifically, due to cultural gender roles and expectations, women may not be able to safely deny sex to their partner (even if they believe he is infected) because if a woman asks her partner to use a condom she may risk being suspected of infidelity. The fear of violence in these contexts forces women to have unprotected sex (also referred to as “survival sex”), thereby increasing their risk for HIV (Wojcicki, 2002). In such cases, the HIV risk stems first and foremost from a disempowered situation, rather than from the individual’s fault of choosing risky behaviors. The risk situation as a cause of HIV infection has also been identified in the context of war, where systematic rape has been historically associated with “the spoils of war.” More recently rape and HIV have been identified as deliberate weapons; for example, in Rwanda the Hutu men who were HIV positive were instructed to rape Tutsi women with the deliberate goal of infecting them with HIV (Chowdhury and Lanier, 2012).

The intravenous drug users also constitute a risk group whose risk is increased and facilitated not only by the behavior of sharing needles for drug use, but also by the *situation* or *environment* in which the users have no access to a clean needle (Rhodes 2002, Rhodes 2005, Strathdee 2010). Because needles are often illegal or hard to obtain, drug users retain used needles. The virus is then easily transmitted between members of the same group. Several countries have opted to increase access to free needles in order to limit the need to share them. Countries that participate in these programs of “harm reduction” are also more likely to provide information and educational resources surrounding safer drug use (Harris 2013). Because risk for HIV infection among MSM is complex, it should be further studied to identify what factors

influence the behaviors and/or situations that facilitate and increase their risk for transmitting the disease. By identifying factors such as sex education, religious influence, condom use, and other limiting factors, epidemiologists could implement programs to educate and decrease the situations in which risk is increased.

Structural Stigma and Health

The third theoretical concept that is useful in the analysis of the relationship between HIV and LGBT is *structural stigma*, as described by public health scholar Mark Hatzenbuehler (2014).⁹ HIV stigma has been well documented and studied. The history of the disease largely contributes to this stigma. Reports most often discuss HIV in reference to MSM and LGBT populations as well as intravenous drug use, sex work, and infidelity, all of which are behaviors that society has traditionally perceived as “deviant” (Herek 1998, Morrow 2012). Stigma related to HIV is found internationally, within different ethnic groups, and among different social classes (Morrow 2012, Li 2014, Grodensky 2015, Chaudior 2009). HIV stigma leads individuals to hide their status to avoid being fired or losing friends and loved ones. Misconceptions regarding the disease and its mechanism of transmission have constructed a nearly universal stigma used to justify discrimination against those with HIV. Stigma has been documented to negatively impact the quality of life and health outcomes for HIV positive individuals as well (Breet 2014, Jeffries 2015).

Structural stigma, specifically, refers to the “societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized” (Hatzenbuehler 2014). The initial spread of the disease, as discussed earlier, led

⁹ Dr. Mark Hatzenbuehler is a Global Health and Sociomedical Sciences professor at Columbia University whose research focuses on sexual orientation and stigma.

officials to classify it first as a disease that only affected homosexual populations, which led to many persistent and pervasive misconceptions surrounding the disease. The classification of HIV/AIDS as a “gay” disease has also structured much of the popular discourse around the disease, as well as the understanding (and misunderstanding) of its transmission. HIV positive individuals have experienced stigma in regards to their perceived sexual orientation, sexual “promiscuity,” and to some extent, drug status. The discourses that depict homosexuality as a “lifestyle choice” have perpetuated the stigmatized status for these groups.¹⁰ This stigma has caused increased risk for contracting and spreading the virus through misconceptions about transmission (Parker 2003).

Analyses of structural stigma further indicate that many individuals over conceptualize the level of stigma they are experiencing. Due to systemic inequality and marginalization of LGBT groups, certain individuals are likely to report feeling stigmatized or prejudiced, despite the fact that their feelings might not be rooted in the actual experience with direct stigmatization or prejudice. The general existence of stigma and the population’s awareness of stigma, however, still impacts the decisions these populations make. This stigma directly influences behavior, including decisions about whether or not, when, and to whom it is safe to “come out,” as well as decisions about getting tested for HIV and other STIs. The experiences of structural stigma (whether actual or perceived) therefore increases risk behaviors in that these individuals are less likely to get tested for fear of testing positive and being stigmatized by doctors, other healthcare

¹⁰ For example, recently in February 2015, the Republican presidential candidate Mike Huckabee when interviewed on the national network CNN portrayed homosexuality as a lifestyle choice akin to drinking or swearing (Bradner February 1, 2015). See website: <http://www.cnn.com/2015/02/01/politics/huckabee-gay-marriage/>. Accessed: 3-12-2015.

providers, or their family and peers (Surlis 2001). Simultaneously, without knowing their status, individuals continue transmitting the disease.

Perception regarding oneself is directly influenced by sociocultural norms and discourses. These perceptions and stigmas in turn perpetuate structural violence by placing groups at risk and maintaining such forms of inequalities (Farmer 2003). This is a sociocultural and medical issue that illustrates the importance of understanding the larger context behind the disease.

James Thomas, a social epidemiologist, proposes that HIV prevention methods have failed because they do not address *why* certain groups are at a higher risk (Thomas 1998). While HIV prevention methods have been successful in decreasing transmission rates, they have failed specific populations. The identification of risk groups, creates the illusion that those who see themselves outside of the risk group see themselves as risk free. In effect, those who see themselves as risk free facilitate their own increased risk. Public health has emphasized and targeted HIV prevention efforts for LGBT populations. These efforts however, have created a degree of illusion wherein which people outside the LGBT spectrum believe they are risk free. For example, African American populations in the United States have experienced an increase in HIV incidence in recent years, particularly among women. As Thomas observes (1999), the focus on gay men as a risk group for HIV has facilitated and detracted from concerns about HIV in heterosexual populations. While this issue is multifaceted, it is related to the culturally significant issue of HIV and bisexual males in the Southern United States (to be discussed later). Bisexual African American men transmit the disease from gay populations to heterosexual women. Because HIV is transmitted easily from active to passive partner, one HIV positive male

can infect several women. The failures of HIV control are becoming more apparent. Efforts to limit risk by decisions, situations, and behaviors could prove more fruitful in eliminating the disease. Social and cultural aspects play a fundamental role in a population's understanding of disease, but also the aspects that may control that disease. In particular, Thomas found (1999) that African American populations were less likely to have received any form of sexual education, but were more likely to participate in casual and/or unprotected sex. This inadequate access to education, one of several factors, is a product of structural violence that perpetuates a lack of sex education in general, ultimately harming individuals.

A recent study found increasing rates of HIV in LBT women where transmission was a result of sexual violence and hate crimes (Logie 2013). These women were raped and contracted HIV from their attacker. The study illustrated that medical literature and epidemiological surveys erased LBT women from risk of the disease, despite increasing incidence. The construct rape places these women in risk situations in which they contract HIV despite a lack of willingness to participate in risky behavior.

These structural factors and forces discussed above including structural violence, structural stigma, and persistent categorization of LGBT populations as a risk group function collectively as “systemic” and a form of structural limitation which places these individuals and groups at an increased risk for HIV infection. Additionally, this population-specific risk ultimately facilitates increased risk to the population at large. A parallel between institutionalized homophobia and racism is useful to consider. Systemic and institutionalized racism have been shown to increase harm and risk to specific racial groups (Farmer 2003). Racism is a form of structural violence in that it is a cultural and political attitude that influences behavior and

society. More specifically, racism creates a structure in which minority populations are less likely to succeed, whether it is academically or economically. Likewise, it is relevant and essential to examine systemic homophobia to understand why a disease that has the capacity to infect anyone, continues to have particularly detrimental effects on the LGBT population. Through a more holistic understanding of how this differential effect is sustained, we can develop new efforts in the public policy and health care settings to limit risk, educate populations, and ultimately decrease HIV transmission.

This Project's Approach

This project builds on the anthropological notion that despite various efforts, the external *etic* point of view can never truly grasp the subjective, or *emic*, experiences of stigma and living with multiple forms of discrimination (Geertz 1973). Simplifying the vast experiences of LGBT people into the level of marriage equality and visibility could never explain the significance and the lived experience of HIV in this group. Similarly, the emphasis of epidemiological approaches on the identification of risk groups offers too narrow a scope and a limited understanding of the complexity of human condition. While acknowledging that, as with any marginalized and oppressed population, the range of experiences by LGBT individuals and communities is wide, this project aims to identify some common trends regarding same-sex rights and experiences of in/equalities and examine these trends in the context of HIV epidemiology. In order to better understand how various problems may play a role in the epidemiology of the disease at the nation state level, they must be viewed from various perspectives and contexts. This leads to the necessity of a cross-cultural, multi-nation comparison. In this project, I undertake the investigation of various HIV risk factors in six countries, and analyze to what degree these

factors are potential “enhancers” of HIV infection. Identification of such factors is complicated, as the factors would have to be common trends both experienced cross culturally and to some degree regulated either by society or the government. In this project, I operationalize homophobia into seven unique factors discussed below to investigate a relationship between HIV and systemic homophobia.

PURPOSE, RESEARCH QUESTION, AND HYPOTHESIS

This research aims to examine the relationship between the degree of systematic homophobia or oppression of LGBT people, as defined by seven unique factors involving political, economic, and social elements, and HIV prevalence through a comparative analysis of six countries. It is expected that the various factors in LGBT people's lives are to some extent controlled or influenced by society and politics, and that there is at least some connection between the systematic oppression of people and the transmission of HIV. This background leads to the following research question: **How and to what extent does homophobia, defined through various political and societal aspects, play a role in the incidence, prevalence, and overall transmission of HIV?**

Based on the above research question, my hypotheses are:

General Hypothesis: Systemic homophobia/oppression of LGBT people in a given country is related to HIV transmission rates.

Directional Hypotheses:

H_{Factor 1}: Countries with greater same-sex marriage equality will have lower levels of HIV transmission.

H_{Factor 2}: Countries with greater laws protecting the LGBT populations will have lower levels of HIV transmission.

H_{Factor 3}: Countries with fewer hate crimes and more protections against them will have lower levels of HIV transmission.

H_{Factor 4}: Countries with greater sex education will have lower levels of HIV transmission.

H_{Factor 5}: Countries with less religious influence will have lower levels of HIV transmission.

H_{Factor 6}: Countries with less medicalization of LGBT culture will have lower levels of HIV transmission.

H_{Factor 7}: Countries with greater LGBT visibility will have lower levels of HIV transmission.

Purpose

Robust evidence shows that there is a relationship between specific categories of people and diseases rates, indicating that sociocultural and political factors influence the transmission of diseases. Given the connection between epidemiology and specific subgroups of populations, the primary purpose and significance of this research is to examine and better understand whether a relationship exists between specific policies and experiences among the LGBT individuals and communities, and the degree of HIV infection in these groups. This understanding can further be used to inform future policy decision-making in the areas of health, public policy, and civil rights in order to facilitate and advance effective methods of prevention and treatment against HIV and STIs in this population, and in general. Additionally a deeper understanding of the relationship between specific groups of people and certain diseases is beneficial in determining more accurate and relevant tactics for treatment for those already affected (Friedman 2014).

Secondarily, this research has the potential to illustrate the imperative role that sociopolitical policies play in the epidemiology of disease on a global scale. If my hypothesis is supported, this research will show the importance of progressive social policy by demonstrating more favorable HIV epidemiology in those geographical and cultural locations. The implications that social policy can directly impact the health and well being of an entire group of people should serve as evidence for the need to strive for greater social equality.

METHODOLOGY

Definition of Terms

In order to begin answer the research question and undertake the analysis of the extent to which homophobia (defined through various political and societal factors) plays a role in the incidence, prevalence, and overall transmission of HIV, I will first discuss the way that this project uses HIV epidemiology, and then how I define and operationalize the multidimensional concept of homophobia.

Defining HIV Epidemiology for this Study

The key elements of HIV epidemiology used to define the dependent variable in this research are incidence and prevalence. Incidence refers to the number of new cases of a disease, while prevalence, in comparison, refers to the overall proportion of affected individuals in comparison to the population at large (Bauermeister 2009). In this research, the population is defined as the population of the given country. The incidence, or new cases, and prevalence, overall proportion of affected individuals, will be determined from this population and then compared cross culturally. Though traditional epidemiological focus has emphasized the identification of risk groups pertinent to HIV transmission such as MSM, intravenous drug users, and vertical transmission incidence,¹¹ this project utilizes the total population incidence and prevalence. As a complex cultural construction, homophobia does not limit effects to LGBT populations. Due to the aforementioned stigma surrounding the disease and the related structural

¹¹ Vertical transmission refers to when an HIV positive mother passes the disease on to a child due to drug noncompliance while pregnant or breast feeding.

violence, homophobia may play a role in the transmission of HIV outside of traditionally recognized risk categories.

In this project, I also chose to record chlamydia infection rates, as available. Unlike HIV, chlamydia does not have a complex social or structural stigma surrounding its transmission; thus, by comparing chlamydia rates a comparison may be made to investigate the role that homophobia and stigma play in HIV transmission directly. If chlamydia rates follow the same trend, other factors may be influencing STI transmission in general; if the rates do not follow the expected pattern for HIV, this data would suggest a stronger relationship between homophobia and HIV transmission. Any attempts to control have limitations. Chlamydia does not follow the same infectious patterns as HIV. While HIV is transmitted sexually, through IDU, and vertically, chlamydia is only transmitted sexually. Particularly pertinent to prevalence data, chlamydia is a treatable and curable condition. While HIV is a lifelong disease, antibiotics clear a chlamydia infection. Regardless, preliminary attempts to control for HIV specifically are important in investigating this correlation.

An important consideration when defining the LGBT population of interest in this study is to acknowledge the Western approach inherent in this research. Gender and sexuality are not constructed and understood uniformly among societies and cultures, and the way that individuals are categorized and categorize themselves is not a universal (Goldstein 1994, McLelland 2005). With this in mind, this research will emphasize an investigative approach into key social and political facets, and how these may affect anyone who falls outside of the heteronormative status quo in their society. In this regard, those who are subject to the various forces of homophobia will be the population of relevance.

Operationalizing Homophobia: Seven Factor Analysis

In order to investigate the effect that the systematic oppression of LGBT people has on the epidemiology of HIV, the expression “systemic homophobia” was chosen to represent the unique factors that the community faces. Systematic homophobia is a multifaceted, complex term that has historically been used to represent the struggles, fear, oppression, marginalization, discrimination, and lack of representation that LGBT people experience both in their day-to-day lives but also as a group and members of the society and the polity (Zita 2002). Because of these complexities and for the purpose of this research, homophobia has been operationalized and broken down into seven defined factors.

In this project, the independent variable is defined as the objective level of homophobia (which will be operationalized below), and the dependent variable is the incidence and prevalence of HIV. Once the level of homophobia has been assessed and described, this level can be compared to the incidence and prevalence of HIV in that country. Six countries were selected: Japan, Spain, the United States, Russia, Uganda, and Canada (selection also discussed below). Each country is being evaluated on the same scale, using the same seven factors for analysis.

The complex nature of operationalizing homophobia was the primary concern upon initiating the research. Homophobia is a multifaceted phenomenon that both has and requires many levels of definitions. The primary question then was how and to what extent homophobia could be evaluated. Unfortunately there is no index level that can easily be applied cross culturally. Understanding of the extent of oppression of LGBT people is largely based on laws and political representation; however this is not a sufficient method for analyzing the true experiences of the population (Bauermeister 2009). In many cases, particularly in the United States, examining policies alone has essentially reduced the problems to “gay marriage”

(Friedman 2014). While same-sex marriage is certainly helpful in investigating the extent to which equality of some rights exists in the population, it is only one factor among many. A common misconception held by society and propagated by the media is that LGBT people are no longer an oppressed population, and that once same-sex marriage has been attained nationally, the problem is solved (Friedman 2014). Unfortunately, this reductionist view has concealed various other forms of suffering experienced by LGBT communities and individuals, including increased depression and suicide rates, increased homelessness, increased violence, and countless other factors that are unrelated to the issue of marriage rights per se (Friedman 2014). Therefore, in this project I take a more expansive approach in order to define and evaluate homophobia. Despite the challenges of operationalizing homophobia, this expansion of factors represents an attempt to better illustrate the complexities of the struggles and experiences in this population, and ultimately better define how these may or may not correlate to HIV transmission.

In an effort to measure complex human phenomena such as for example machismo or intelligence, social scientists “operationalize” these terms to attempt to quantify and measure these traits (Bernard 2011). “Unidimensional” concepts that can be easily quantified or measured, such as age, height, or weight do not require operationalization (Bernard 2011; p. 29). Because social research focuses on associations between complex, “multidimensional” factors that may or may not be traditionally quantifiable, operationalizing is useful in creating meaningful relationships between complex concepts. Many of these aspects are conditional or have several intersecting factors that require analysis before data can become meaningful (Bernard 2011; p. 30), yet quantification of complex terms is extremely useful in exposing how they operate and impact populations. For example, the concept of “sex-role identity” has been

operationalized to critically evaluate how perceptions of maleness and femaleness impact different factors such as individual goal making, overall health, and healthcare decision making. The Bem Sex Role Inventory, as it is called, was operationalized by psychologist Sandra Bem and has been implemented in hundreds of studies since its development in the 1970s (Bernard 2011; p. 32).

In the process of operationalizing complex phenomena, variables must be identified regardless of how easily they are measured or observed. As complex conceptual issues are quantified, one concern is reducing the probability and amount of error (Bernard 2011: p. 36). Concepts such as religiosity (also relevant in this project, as will be elaborated below) are often subjective experiences, perspectives, or beliefs. Individuals in religiosity studies often make subjective self-assessments on this issue. Creating criteria for a measurement or assessment, scientists are able to meaningfully quantify these terms.

This study operationalized homophobia as a “multidimensional” phenomena, into seven variables or factors, as follows:

Factor 1: Degree of Marriage Equality: As a common factor for evaluating how progressive a country is in terms of LGBT equality, the status of same-sex marriage is inherently essential to measuring homophobia in the country. Granting access to marriage to same-sex couples creates a measure of equality, allowing all people, regardless of sexual orientation, access to the same status and benefits that marriage rights offer. Therefore, movements towards marriage equality indicate less or declining homophobia; legislation prohibiting unions and marriage indicate higher levels of homophobia.

Factor 2: LGBT Laws: Similar to marriage equality, aggregating information about the status of LGBT protections in the law is indicative of the level of homophobia in the country. These laws include the legal status of same-sex sexual activity, anti-discrimination legislation, the ability to serve in the military, access to child adoption and family planning tools, and the ability to donate blood. Measuring the status of these factors is essential to developing an understanding of the degree of homophobia in the country as less homophobic countries would create legislation that extends equal opportunity, access, and protection to all citizens, regardless of sexual orientation. Not providing these protections and opportunities creates explicit discrimination.

Factor 3: Hate Crimes: LGBT individuals are often more likely to be targeted as victims of hate crimes. This factor aims to investigate the degree to which the country handles hate crimes. High rates of hate crimes against LGBT individuals indicate a higher level of homophobia in the country. Similarly, how the country handles these hate crimes is important. If the country pursues, prosecutes and convicts those who commit hate crimes, it is indicative of a less homophobic policy. Conversely, by not identifying LGBT violence as a hate crime, or identified hate crimes going without prosecution, indicates that these countries are promoting or condoning homophobic actions.

Factor 4: Sex Education: While sex education itself is often a controversial topic in the US, it has been linked to STI transmission (Bauermeister 2009). Regions with increased sexual education have historically been linked to decreased STI transmission rates (Bauermeister 2009). Theoretically this makes sense as well. Given more information, people are more aware of the

risks associated with sex and are more able to make informed decisions when sexually active. So called “abstinence-only” programs or lack of sex education altogether has been linked to higher STI rates because of the lack of information and consequently poor understanding of risk factors and prevention methods. In the context of the LGBT population, this risk is even higher. Sex education in most places rarely explicitly discusses same-sex behavior or risks (Bloom 2001). Because condoms are generally used to avoid pregnancy, beliefs that same-sex practices do not require a condom still exist (Bauermeister 2009). Certainly, this factor alone likely contributes to the transmission of HIV. Overall, an assessment of sex education is an important factor for my analysis.

Factor 5: Medical Understanding: The medical governing bodies such as medical associations and psychological associations often publish their positions, ethics, and opinions on relevant matters. Homosexuality, sexual orientation, and same-sex sexual behavior are among these topics. The groups have published research that supports their opinions and use these publications to support or oppose legislation. Countries that have medical boards that medicalize sexual orientation as a pathology or a lifestyle choice that can be treated with mental health treatments would be considered more homophobic than countries where homosexuality is not medicalized and instead seen as a normal variant within a spectrum of human sexuality (Epstein 2003). Position of the medical community is highly significant as residents in the given country could be influenced in how they understand homosexuality and they could also turn to these expert opinions as justification for their beliefs about the LGBT population. Countries with

medical associations that discuss sexual orientation in terms of orientation or identity are less homophobic.

Factor 6: Religious Pervasion and Religiosity: Religion is often a justification for homophobic beliefs or actions (Whitehead 2010). Naturally, in theocratic states that forbid homosexuality for reasons based on a particular moral or religious doctrine, the oppression would be greater. Outside theocracy, however, religion is often pervasive within the society and/or the government. Religious individuals within the government may use their particular religious convictions to enact legislation or move their citizens in a direction that conforms to their religious doctrine. Religiosity, or the level to which citizens actually commit to and practice their religion is also indicative of homophobia as more religious individuals will justify their homophobic beliefs and actions with their religious convictions. Even when religious individuals recognize the biological etiology of sexuality, they are more likely to continue their prejudicial attitude toward LGBT people when compared to non-religious individuals (Whitehead 2010).

Factor 7: Visibility of LGBT: Similar to marriage equality, the visibility of LGBT groups, individuals, and role models in the public space is frequently used to measure the level of progression in LGBT equality in countries. Those countries that have prominent LGBT figures such as CEOs, athletes, politicians, actors/actresses, etc., illustrate that LGBT people can be just as successful as their heterosexual counterparts, and brings attention to the fact that LGBT individuals are present in every part of society, regardless of race, ethnicity, class, gender, or age. Low visibility is an important factor to consider not only as a potential sign of the LGBT

peoples' own need to hide their presence due to fear and stigma, but also as a potential effort on the part of the society and the media to keep these groups at the margins and invisible. Similarly, visibility in the media, such as characters and prominent figures on the television illustrate the greater acceptance of LGBT people in the culture. Thus, in my analysis an equal proportions of prominent figures and characters indicate less homophobia; a smaller proportion indicates homophobia.

Each of the seven factors above is analyzed in this project using the aggregation of information from a number of data sources, including quantitative and qualitative peer-reviewed research, policy documentation, media sources, popular press, and primary accounts and reports published by non-governmental organizations. Based on these data, a score will be calculated for each country and each factor. Once scored using the chart (see Chart 1 below), these scores will be used to compare the degree of homophobia with the incidence and prevalence of HIV. Specifically, the seven factors are aggregated into a chart with a scale ranging from 1-10. The higher number represents the less homophobic context; a lower number corresponds to more homophobic context. The chart used for scoring is visualized on the following page in *Table 1: Operationalized Homophobia Score Sheet*.

Table 1: Operationalized Homophobia Score Sheet

Score	1-2	3-4	5-6	7-8	9-10
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal-no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy
Rate of violent crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher
Pathology vs. Orientation	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or more accepted	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs

Selection of Countries for Comparative Analysis

The next step in this project was to choose the countries that would be evaluated. A diverse selection of countries would be necessary to investigate the topic cross-culturally, and cross-politically. Considering that sexual minorities are defined differently in different cultures, the chart approach was necessary to give a more objective rating to the experiences of people outside of the heterosexual majority. In order to generate variety, countries that historically or currently have a certain polarity towards LGBT populations were selected. Comparative country analysis is a widely used method in investigating culturally significant differences. Specifically, comparative political scientists use the comparative method¹² to systematically analyze a limited sample size (Lijphart 1971). The comparative method is limited by many variables with a small number of cases, however, the method allows for a deep, intensive investigation (Lijphart 1971). A certain degree of selection bias is common within these studies; however, comparative analysis allows for an unrivalled investigation providing a depth for understanding how certain events come about (Gedess 1990). They contribute then to modifying existing theories and exposing anomalies in current systems by providing details and creating theoretical frameworks for possible future studies (Gedess 1990).

An important requirement for my analysis was to also ensure that sufficient data sources regarding the seven factors described above were available for each of the selected countries. Equally critical for my analysis was the availability of information regarding the epidemiology of HIV. For these reasons, Japan, Spain, the United States, Russia, Uganda, and Canada were

¹² The *comparative method* is unique to the *experimental* or *statistical* method of research in that there are too few samples to create systematic review. The comparative method is useful for finding and developing trends that can be evaluated and investigated through further analysis.

selected. The selected countries can be loosely grouped into three categories: (1) more homophobic, (2) less homophobic, and (3) “in between” status.

In the first category are those countries that were more homophobic from the perspective of experiences and reports in the media. Given recent events and current headlines, information was far from scarce regarding both Russia and Uganda. Both countries have been in international media headlines for their explicit criminalization of sexual minorities (King 2013, Stolyarova 2014). The abundance of relevant and current information made these two countries ideal candidates for this category.

The second category that was easily defined focuses on those countries that were reported in the media and also based on policy reports as highly open and more equal regarding sexual rights. Given the history and current events regarding laws and marriage equality, Spain and Canada offered abundant resources to analyze. These countries were thus chosen due to their perceived lack (or low level) of homophobia, and the abundance of data sources regarding their LGBT populations (Berna 2012, Rose 2012).

The most difficult group to define were those that were somewhere in between the explicitly oppressed and those that were considered more equal. The research garnered from this “work in progress” group was particularly important as these nations would likely show varying scores among the seven different categories of factors that were assessed. These variations have the potential of showing the effects of *specific factors* (rather than only the aggregate scores). Additionally, these factor-specific effects can also illustrate the need to focus work towards increasing equality in particular aspects of the society or laws in order to achieve a more objectively equal state. For this category, I selected the United States and Japan given their

current events and abundance of information. These are both interesting cases, as I explore later in the thesis, with very different reasons for their current “work in progress” status.

Each of the six countries is objectively scored in each of the seven categories in order to determine an *individual score* and a *composite score* out of a maximum of 70. A score closer to 80 indicates a less homophobic state, while a lower number indicates more homophobia, as defined earlier. The *score of each factor* for a given country is used to compare to the epidemiology of HIV. The incidence and prevalence of HIV for each country, was collected from reports by the World Health Organization, the Center for Disease Control, as well as individual reports from the countries as available. These numbers were then compared to each subscore and to the total score. This information could then be used to draw conclusions through a comparative analysis between each factor that was evaluated as well as the country at large. This approach aims to illustrate both the effects of the relevant factors as well as the overall effect of homophobia on the spread of the disease.

CANADA

Introduction

In July of 2005, Canada became the first country outside Europe, and the fourth nation in the world to begin granting same-sex marriage permits (*New York Times* 2005). The decision was far from unanimous but the support for it at the time was nearly unrivalled (Lehman 2004). What is less known is the long history of LGBT support Canada holds, one that has shaped their current standing as a world leader in LGBT equalities and freedom. This is evident in the advanced rights and laws regarding LGBT people compared to anywhere else in North America. Therefore, I selected Canada for this project due to this unparalleled level of equality. To examine the relationship between HIV infection rates and homophobia (as defined in this research), it is important to include a country that based on available evidence could be described as less homophobic. Through careful analysis of the seven factors (defined in methodology), Canada scored the highest out of every country analyzed.

Below is the Result Table for Canada with the specific scores assigned in each of the seven categories, listed vertically in the left column. The assigned score ranges are indicated by a highlighted yellow cell, and scores for each factor are then listed at the end of each row, in the far right column labeled "Score." Each of the seven factors and evidence for the resulting scores are described in detail below the table.

Table 2: Operationalized Homophobia Scores in Canada

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	10
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal-no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	10
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	9
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	9
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	7
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	7
Visibility of LGBT	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or more accepted	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	9
Total						61/70

Level of Marriage Equality

As mentioned, Canada became the first North American country and the fourth overall country to grant same-sex couples legal recognition and access to marriage. Prior to 2005, support for same-sex marriage was far from unanimous and the topic was hotly debated throughout the 1990s and early 2000s (*M v H* 1999, *Halpern v Canada* 2002). The issue reached the Supreme Court due to the unusual way in which same-sex marriage came about. The Canadian Constitution indicates that marriage is responsibility of the federal government; however, same-sex marriage came about much the way it has in the United States, one province at a time. Ontario and British Columbia began the movement, recognizing same-sex marriage in 2003 (*Halpern v Canada* 2002, *Barbeau v. British Columbia* 2003). Critics, however, argued that Canadian law would require federal recognition and support for same-sex marriage before marriage licenses could legally be issued on the local level. Despite the controversy, marriage licenses were granted in provinces that supported same-sex marriage until 2004. In 2004, the same-sex marriage controversy culminated in a Supreme Court ruling that the federal government did in fact have the sole authority to amend the definition of marriage, and also that same-sex marriage was indeed constitutional (*Canada Supreme Court: re Same-Sex Marriage* 2004). Since 2004, same-sex couples have enjoyed the freedom and choice to be married (*Civil Marriage Act* 2004). As Canada was one of the earliest countries to pass such legislation, it sparked a surge in what became known as “marriage tourism” in which same-sex couples from other countries, particularly the United States, flocked to Canada to get married (Badgett 2006, Boyd 2006). This form of tourism was very common until only recently when the United States experienced a surge in marriage equality movements.

Marriage equality in Canada can now be described as total marriage equality policy. Recognized on a federal level, no province of Canada is allowed to withhold marriage licenses from same-sex couples (*The Civil Marriage Act 2005*). There are no stipulations and no discriminatory factors that impede same-sex couples from getting married. For example, some states in the United States require same-sex couples to obtain their marriage license only in specific locations, a restriction that does not apply to heterosexual marriage licenses. The process for applying for a marriage license is inclusive referring to applicants as “Applicant” and “Joint Applicant” (*Statutory Declaration of Legal Marriage*). This language likely helps same-sex applicants in knowing they will not experience complications throughout the process. Same-sex marriage has also been extended to immigrant populations and marriages between a citizen and an immigrant.

Marriage equality appears to be experienced equally after the marriage event takes place. Married couples in Canada enjoy a wide range of tax breaks and other benefits, all of which are applied to same-sex couples as well. Several studies have also indicated same-sex marriage is experienced well in Canada (Boyd 2006, Smith 2007, Chauncey 2009). Federal recognition also encompasses policies in the workforce. Companies must extend all privileges to all couples (*Civil Marriage Act 2005*). Canadian health policies in their universal healthcare benefits are also indistinguishable for same-sex married couples. This is particularly important as same-sex married couples are allowed all healthcare rights as heterosexual couples, including rights regarding visitations and health-related decision making.

Given the early history and the extensive efforts of the Canadian government to ensure equality in all facets of marriage, marriage equality factor in Canada was given a score of 10.

Laws Regarding LGBT Populations

Given the widespread attention given to marriage equality, particularly recently in the United States, often overlooked are several other factors that directly impact the quality of life of LGBT people are often overlooked. While marriage equality has spearheaded the LGBT movement in several countries, the movement is often critiqued for overlooking a vast sea of problems that plague LGBT populations. Some of these issues include difficulties related to adoption, discrimination in the workforce, as well as in services and labor, and employment in the military.

Contrary to what has been seen in the United States, Canada experienced the majority of their LGBT movements prior to the movement for marriage equality.¹³ This trend to increase freedom for LGBT people in Canada is unparalleled and shows a deeper and more thorough acceptance and understanding of LGBT populations. Canada was the only country to score a 10 in this section as they are the only country to federally, systematically, and universally eliminate inequality in a variety of ways. The three major areas of laws that are of significance are outlined below and include: (a) adoption and child rearing laws, (b) anti-discrimination laws, and (c) privacy and identity laws.

Adoption and Child Rearing

LGBT people have access to a variety of avenues in which to form a family. Canada provides same-sex couples with legal access to both adoption and assisted reproductive technologies and procedures in order to have children. In the case of adoption, access is open to both joint adoption and stepchild adoption (*Canadian Charter of Rights and Freedoms* 1985).

¹³ Efforts in the United States in the late 1960s and early 1970s, or the so called Stonewall era helped to raise awareness and visibility of LGBT issues in America; however, nothing in terms of protection or equality was added as a result of these movements, they simply got the ball rolling. A post marriage equality America will have significant work to eliminate systemic homophobia in other areas.

This means that couples have the option to jointly adopt a child or if they have children from previous relationships, they may adopt each other's children. In terms of assisted reproductive technologies and procedures, access is open and equal for all couples (Fiona 2013). Women in same-sex partnerships have access to in vitro fertilization options to become pregnant.

Throughout the pregnancy, female couples are granted all healthcare rights afforded to heterosexual couples, including the right to visitation, decision making, and being present during medical visits (Kashmeri 2008, Fiona 2013). Men in same-sex partnerships are given access to surrogacy options. While the surrogate pregnancy process is largely commercialized,¹⁴ it is legal and open for all couples.

Anti-Discrimination Laws

Anti-discrimination laws have largely been in effect since 1998. LGBT people are protected from discrimination in any form in the workforce. Companies and hiring managers are not allowed to hire based on sexual orientation or gender identity. Likewise, companies cannot legally fire someone for being LGBT (Human Rights Commission 1996). Individuals also have the right to sue if they feel their workplace has discriminated against them. Workplaces may also not discriminate on the basis for promotions or job changes. Benefits afforded to spouses must be made available to all married employees. Anti-discrimination law also protects individuals from being denied services (Human Rights Act 2002). This means that companies cannot deny service, sales, or any other good to a person on the basis of their identity or orientation. These laws also protect individuals from hate speech and violent crimes. It is illegal to engage in physical or verbal harassment on the basis of sexual orientation or gender identity, and

¹⁴ Private organizations are the general methods for obtaining surrogacy options. These organizations contract women to be surrogates, matching couples to a surrogate for a price.

individuals may prosecute if they feel an attack was motivated by either of these factors.

Canadians have been legally able to serve openly in their military since 1992, which is earlier than the legislation in Canada that extended the majority of rights and protection to LGBT people in 1998 (*Douglas v Canada* 1993). This lack of discrimination is even present in the health field as MSM and women who have sex with MSM are able to donate blood (*Changes to Blood Donor Guidelines* 2013).

Privacy and Identity

The right to privacy and identity are often overlooked in terms of LGBT equality. In several countries, same-sex sexual activity is hotly debated and legal recognition of gender identity is rarely accessible. Many countries have turned both of these issues into matters of privacy and identity. Some countries have gone as far as to say it is a matter of public interest to protect citizens from LGBT sexual activity and that by making it illegal, the public is better protected and better served. In some countries in the past, and in some currently it has been a less than subtle way to make it illegal to be part of the LGBT population.

Sexual activity in Canada has been described by the government as a subject not allocated to their power stating that “there’s no place for the state in the bedrooms of the nation” (Trudeau 1967). Canadian law has federally banned limitations on sexual activity regarding LGBT populations since 1969, the earliest law of its kind in the world. While some politicians have tried to argue against it, early legislation adding protections and provisions for LGBT people has largely eliminated the battle that many other Western countries faced in the 1990s. This issue is of particular interest to HIV transmission. The degree to which the governing body limits or represses sexual activities, particularly those localized to specific groups, likely

increases the risks that those groups will take. This is a prime example of structural violence, discussed earlier in this thesis. By creating a structure in which LGBT people cannot have sex, they instead do so in clandestine and therefore riskier ways. This systemic homophobia would therefore directly facilitate the transmission of HIV.

Likewise, structural violence can also be used to analyze the policies behind gender identity. Canadian policy regarding legal recognition of gender identity is one of the few limiting factors that Canada has regarding LGBT policy. Legal recognition and ease to change gender vary depending on the province; however, as of 2014 all provinces allow for individuals to legally change their gender (LaViolette 2014). The issue was decided by each province and for now there remains no federal policy regarding gender identity. Regardless, transsexual people are recognized throughout the country and able to legally identify with their gender identity. Access to healthcare has some limitations regarding transgender people, as the medicalization of gender identity is pervasive as will be discussed below. However, despite this drawback, Canada received a score of 10 in LGBT laws due to the unrivalled level to which their laws pervade and systematically eliminate inequality.

Rate of Hate Crimes

Hate crimes are often separated as violent hate crimes and non-violent hate crimes. Non-violent hate crimes include public incitement or destruction to property directed against LGBT individuals. Violent hate crimes include battery, assault, and harassment.

Police reports released in 2012 indicated that 1,414 hate crimes took place in Canada (Allen 2012). Of these, 13% or 184 were reported to be implicated with sexual orientation or gender identity. The victims of sexual orientation and gender identity crimes range in age from

12 to over 55 (Allen 2012). The majority of victims are white and male. Eighty percent of victims were biologically male, which indicates a particular bias, at least in a more active form, against gay men and transgender women. Society has traditionally maligned effeminate males, thus LGBT hate crimes tend to impact biological males at a higher rate. Those aged 18-24 comprised 33% of victims and 23% were under 18, comprising the two highest groups and together making up more than half of victims (Allen 2012). This may be caused by reporting error in that younger people may be more likely to identify as LGBT. Similarly, race and ethnicity may limit who reports identifying as LGBT. However, the Canadian demographic is comprised largely of people identifying as white (Allen 2012).

The person accused of the hate crime was most often in the age range of 12 to 17 at 44% of perpetrators. People between the ages of 12 and 24 comprised 64% of the accused. Minors committed almost half of the reported crimes. Non-violent crimes comprised 62% of those reported. The most common violent offense was assault at 22%. The accused was also most often white and male. In sum, the majority of sexual orientation and gender identity hate crimes were perpetrated by young, white males against young, white males (Allen 2012).

Hate crimes are very challenging to record accurately and the Canadian record is not immune to this challenge. The police and the government believe there is a high degree of underreporting regarding hate crimes, particularly those motivated by invisible identities¹⁵ in that victims of these hate crimes may not report that they are LGBT. Because hate crimes are motivated by some cultural factor, many victims fear repeat offenses. Although the majority of reported victims did not know their attacker, it is possible that many unreported attacks are

¹⁵ Any aspect of one's identity which one may hide is referred to as an invisible identity. While race and ethnicity are aspects of one's identity that generally cannot be hidden, LGBT identity is not always immediately apparent.

familiar with their attacker and choose not to report for fear of retaliation (Allen 2012). Canada received a score of 9 due to the comparatively low levels of hate crimes related to LGBT people, and because of the laws regarding prosecution of those who commit them.

Medical Understanding

The Canadian Psychological Association (CPA) lists several policy statements regarding their official positions on key issues of interest here, including sexual orientation and gender identity. The CPA accredits Psychology programs including Masters, Ph.D, and undergraduate degrees. They also oversee and generate policy regarding psychology research and ethics. Their policy statements are published on their website. The following are policy statements that illustrate the rejection of pathology associated with LGBT people.

2010 - Gender Identity in Adolescents and Adults

The Canadian Psychological Association affirms that all adolescent and adult persons have the right to define their own gender identity regardless of chromosomal sex, genitalia, assigned birth sex, or initial gender role.

Moreover, all adolescent and adult persons have the right to free expression of their self-defined gender identity.

The Canadian Psychological Association opposes stereotyping, prejudice, and discrimination on the basis of chromosomal sex, genitalia, assigned birth sex, or initial gender role, or on the basis of a self-defined gender identity or the expression thereof in exercising all basic human rights.”

1996 - 2 Equality for lesbians, gay men, their relationships and their families

The Canadian Psychological Association supports the inclusion of sexual orientation as a protected ground of discrimination against lesbians, gay men, their relationships and their families in all human rights legislation, public policy, regulation, procedure and practice; and

The Canadian Psychological Association strongly opposes prejudice, bias and discrimination on the basis of sexual orientation in all areas including spousal and family relationships, benefits and privileges, employment, goods, services, facilities, housing and accommodation. (Policy Statements 1996).

The Royal College of Physicians and Surgeons of Canada is the accrediting body for all medical positions and professions. They regulate accreditation for schools and oversee the training of medical professionals. They also outline what skills and content must be mastered by residents and fellows throughout their medical training. Medical training regarding LGBT topics are outlined below.

Disorders of reproduction..., including disordered sexual development and gender identity, abnormalities of puberty, menstrual

disorders, hypogonadism, infertility, and hyperandrogenic states.

Fellows will have an introductory knowledge of the following:

2.1.3.1. Etiology, symptoms, course of illness and treatment of:

2.1.3.1.1. Sexual and gender identity disorders”

In all aspects of ... practice, the graduate must be able to address issues of gender, sexual orientation, age, culture, ethnicity and ethics in a professional manner (Objectives of Training 2014).

The medicalization of sexual orientation appears to be limited, in that sexual orientation is treated as normal sexuality, rather than as a condition in need of medical attention. Medical professionals receive little training regarding subject specific content regarding sexual orientation. One caveat is that medical education often discusses sexual orientation only in reference to HIV (*Ongoing LGBT Health Disparities 2012*). Medical professionals are trained to view LGBT people as high risk for HIV, which may influence the healthcare decisions of the LGBT individuals, as discussed earlier in relation to risk groups and stigma. HIV training of providers is almost always linked with sexual health and is one of the only topics covered in reference to same-sex health. There is no information regarding the treatment of sexual orientation or discussion of it as a condition, illness, or disorder.

Conversely, gender identity is highly medicalized. As seen above, medical professionals are trained to work with transgendered people as “disordered” and to look for signs and treat the

illness. Medical organizations do not discuss Gender Identity Disorder in terms of deviance, however, they discuss treatment options and train medical professionals to diagnose and treat what they refer to as a condition. Transgendered people are forced to go through the medical system in order to get approval, a diagnosis, and seek treatment. While research has shown this may not be the most effective method for improving transgender health as not all individuals feel the need to pursue medical assistance because of their non-conforming gender identity or expression, access to healthcare is available and many transgendered people enjoy access to hormones and other health procedures to transition, if they so choose (Lee 2008, Epstein 2003, Rotondi 2013).

Canada received a score of 9, losing only one point due to the over-medicalization of transgender health. Otherwise, the medical understanding identifies LGBT people with language that avoids pathologizing sexual orientation and avoids harmful and unnecessary treatments.

Sex Education

Critiques of sex education programs often indicate that it is not as effective as it could be. Critics often cite that emphasis on abstinence is an inherent limitation of existing programs as they do not educate youth on STIs, nor do they emphasize safe sex practices. Limited access to quality sex education in Canada creates structural violence in that less information available to educate the public, and the younger generation in particular, has caused harm in the form of increased STI transmission rates, increased teenage pregnancy, and increased unsafe sexual activity (Kohler 2007). This deficiency of information is particularly notable in terms of LGBT sexual health. LGBT sexual health education is nearly universally absent within the education system in Canada. LGBT youth are forced to actively inquire or seek out information from the

Internet, library, or other external sources. Therefore, this causes more harm to LGBT individuals as existing sex education programs disseminate even less information regarding the risks, benefits, and overall health factors specific to their sexuality and sexual behaviors.

Canadian access to sexual education is the most progressive in this study. The Sex Information and Education Council of Canada (SEICCAN) is an organization dedicated to increasing research and access to information regarding sexual health. It publishes a scholarly journal regarding research on human sexuality, sexual health, sexual behavior, and sex education titled the *Canadian Journal of Human Sexuality*. In addition to this peer-reviewed journal, the organization provides information to employers, the government, and public schools in Canada regarding sexual health. They provide guidelines, outlines, and criteria for what they term “satisfactory sexual education” which includes information about condom use, STI’s, and safer-sex practices (McKay 2010). They have identified a lack of LGBT sex education and have worked to increase information and ease of access to it. There is not, however, comprehensive regulation ensuring access to information, nor has there been effective government intervention to ensure universal application of sexual education in the Canadian school system (McKay 2010).

Eleanor Maticka-Tyndale, a prominent sexual health researcher in Canada in particular has identified (2008) the need in Canada to continue to pursue open policies regarding sexual education. Her research focuses on sex education and its deficiencies in Canada. She has particularly taken note of the need to increase access to LGBT information. She has also studied the effectiveness of intervention based training on sexual health and the efficacy of public sexual

education and found an increased need for comprehensive sex education including condom use and safer sex practices (Tyndale 2009).

While sex education clearly needs improvements in order to better serve the public and youth, Canadian sex education is comparatively well advanced. The presence of an organization dedicated to disseminating and researching this information is unique to Canada, at least one with such a strong presence. Canada received a score of 7 in regards to sex education with detractions due to the lack of universal application in the school system, the deficiency regarding same-sex health information, and the need for increased access to comprehensive sex education.

Religious Influence on Policy

Despite Canada's advanced efforts to eliminate homophobia in many facets unrivalled by other countries, social homophobia remains prevalent (Adrien 2013). This more traditional definition of homophobia focuses on the social inequalities in which LGBT people are subjected. A 2010 cross cultural investigation of homophobia in Belgium and Canada illustrates that despite policy-level advances, there remains a high degree of hostile feelings towards LGBT people in their day-to-day living and society at large (Hooge 2010). The results in this study showed that hostility against LGBT people is particularly evident in high school aged children, and older generations. Both groups largely cited religion, particularly Islam and Christianity, as their main reason for feelings of hostility. The study showed that adolescent boys were far less likely to be tolerant of LGBT issues despite the study's emphasis on Belgium and Canada, two traditionally socially progressive countries (Hooge 2010).

Of relevance in the evaluation of religious influences in a given country is the question of the separation of church and state. The Canadian government is unclear about the official stance on separation of church and state, as no specific stance has ever been explicitly declared by the Canadian state and no official doctrine or document dictates the policy of separation of church and state. Despite this, it is a prominently held popular belief that there is a significant separation of church and state. Unfortunately, there is no way without a formal doctrine to enforce separation of church and state. However, a recent study found the degree of religiosity in Canada to be very low (Marger 2013). Though both the United States and Canada have seen increased trends towards secularization, Canada has increased dramatically (Marger 2013). The study also found a strong correlation between views on homosexuality and religious adherence. Only 30% of Canadians think you must believe in God to be moral, 70% believe homosexuality should be accepted and 71% believe the government and religion should be separate (Marger 2013; p. 73) The diminished role of religion in the state and the decreasing rates of religiosity indicate a score of 7 for Canada.

LGBT Visibility and Media Representation

Canadian LGBT visibility is quite strong. There are over 50 prominent LGBT public figures ranging from legislators, actors, singers, comedians, journalists, filmmakers, TV hosts, and multiple Olympic medalists (*50 Gay Canadians We Love* 2013). There is visibility in both the number of prominent figures, as well as in their variety and quality of work.

Characters on Canadian television shows are varied and extensive (*Index of Television* 2013). With a variety of television shows and movies featuring prominent LGBT characters, Canadians are privy to an array of LGBT representations that not only normalize LGBT visibility

but also offer cultural role models that are inclusive. While some portrayals are caricatures or mocked, there are a variety of LGBT characters who are becoming less one-dimensional.

Canada is host to a variety of LGBT pride events including the prominent Toronto Pride Week (*Toronto Pride 2015*). This large-scale, week long event provides a public, visible event for LGBT people and emphasizes awareness, safer sex practices, education, and fun.

Having a large volume of quality LGBT characters and prominent LGBT figures gives not only quantity, but quality to the visibility that LGBT people experience. Visibility in Canada is by no means equal in terms of proportional representation, however, and thus receives a score of 9.

Infection Rates

The table and graph below illustrate the HIV infection rates and the score for comparison. The chart indicates prevalence and incidence for HIV and Chlamydia, used as a control, in reference to percentage and total number of people. It is also relevant to note that HIV incidence has decreased in recent years and Chlamydia incidence and prevalence have increased. The prevalence of HIV continues to increase despite the drop in incidence because treatment options have established a longer lifespan for HIV positive individuals. Despite the drop in incidence, a longer lifespan creates a higher prevalence.¹⁶ Data for transmission rates comes from the Public Health Agency of Canada (*At a Glance 2012, A Continued Public Health Concern 2012*).

Table 3: Infection Rates in Canada

	HIV	Chlamydia
Prevalence	.2% (71,300)	.7% (246,120)
Incidence	.009% (3,175)	.25% (87,900)
Trend of Incidence	Decreasing	Increasing

¹⁶ The epidemiological equation $P=ID$ describes this relationship. The prevalence (P) is proportional to the incidence rate (I) times the duration of the disease (D).

Figure 1: HIV and Chlamydia Prevalence in Canada

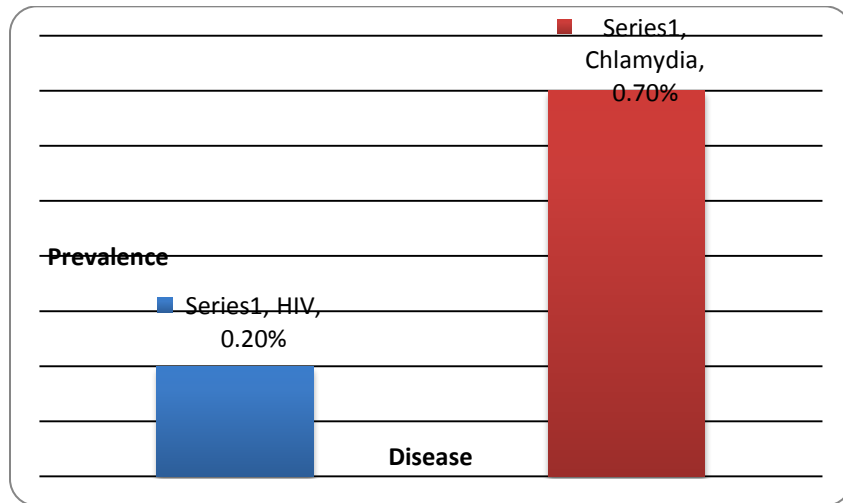
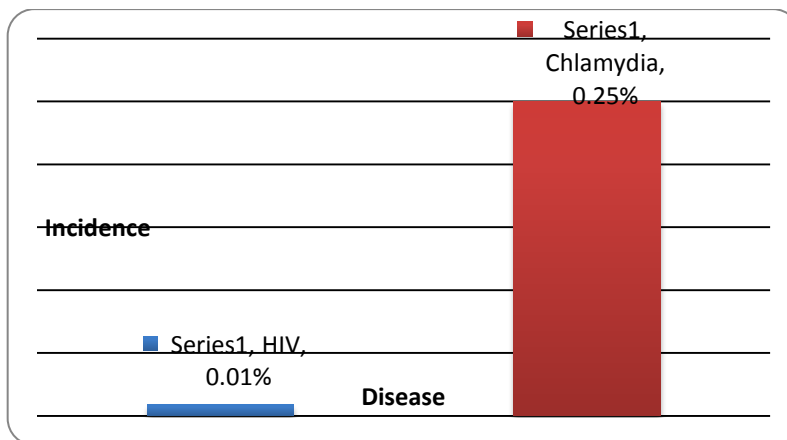


Figure 2: HIV and Chlamydia Incidence in Canada



Chlamydia transmission rates are higher in both categories. While HIV incidence has been decreasing in recent years, chlamydia rates are still increasing.

Conclusion

While it is clear that Canada is the most progressive country in this study, this analysis also illustrates that that progress must still be made in Canada. Efforts to improve the understanding of LGBT culture in medicine could be improved.

Despite the various efforts to avoid systemic homophobia in Canada, LGBT people still are at increased risk for depression and suicide and are more likely to experience harassment, both verbally and physically. LGBT youth in particular still struggle to face their identity due to heteronormativity institutionalized by the media and other entities. This is by no means to detract from the vast efforts made and the unparalleled level to which Canada has attempted to eliminate homophobia on a federal level. At this point, homophobia in Canada is an issue of social and cultural normativity, and can only be corrected with increased time and efforts to improve those areas that are deficient. Hate crimes in Canada still disproportionately affect LGBT individuals and transgender health is still widely medicalized. LGBT sex education is most often omitted, leaving sex education not only weak, but exclusive. This exclusivity generates a structure of violence in limiting an understanding of how STIs spread among LGBT individuals while also translating a sense of exclusivity in being heterosexual. This, in turn, may also contribute to structural stigma against LGBT groups. Canada's lack of a formal separation of church and state creates an uncertainty of the role the church can have in policy decisions. The visibility of LGBT people in Canada is among the highest but is far from proportional in that heteronormativity in the media persists. With time and increased efforts, however, Canada has set a strong example of how to begin eliminating systemic homophobia.

SPAIN

Introduction

The historical relationship and strong association between the Spanish and the Catholic church creates an interesting dynamic in this study. A country that many would expect to be largely homophobic due to a longstanding and pervasive relationship with the church was one of the earliest to make same-sex marriage legal. The law was ratified in the summer of 2005 with a majority of the population (66%) in support. Despite majority support for same-sex marriage and other LGBT issues, the Catholic Church has engaged in a 10 year struggle in the country to repeal the laws. They have also actively supported legislature and made efforts to make the marriages themselves harder to obtain. The widespread support for LGBT populations in the country is directly opposed by the pervasive and controlling Catholic Church. Despite 54% reporting going to church only for weddings and funerals and 19% reporting going every week, the Church remains a powerful sphere of influence in policy. While the Church has certainly lost much of the influence it has historically held, it remains an influential party within politics. Table 2 indicates the assigned scores in Spain.

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	10
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal- no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	9
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	8
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	10
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	7
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	6
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or more accepted	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	9

Table 4: Operationalized Homophobia in Spain

Level of Marriage Equality

Spain became the third country to grant same-sex marriage licenses starting in the summer of 2005. The vote was far from unanimous but the degree of support was also surprisingly high as 66% of the population reported their support for the law at the time. (Giles 2005) The issue, however, has been tumultuous throughout its ten-year history. Most notably, the People's Party in Spain won the 2012 election. The leader, Mariano Rajoy actively supported repealing the law, working within the government to repeal the law from the Constitutional courts. The case, however, proved fruitless when the Court upheld the law in an 8-3 decision (*Mendicoa v State* 2012). While it is unlikely the law will ever be repealed, this example illustrates the complexity of the issue. Despite a ten year history of same-sex marriage, the opposition is still strong from within, highlighting that same-sex marriage does not eliminate homophobia and that these issues are dynamic and less static than imagined. The courts have faced at least three notable examples of retaliation against the laws.

The Spanish laws regarding marriage equality were less direct or straightforward than other efforts. While the law was passed, it omitted several key factors left to be debated throughout the last ten years. One primary issue was the issue of residency. Soon after the vote, many judges started looking for excuses to ignore the law. Several cases were evaluated when judges argued they would not have to or be able to marry same-sex couples where one was from another country. Ultimately, the courts decided that same-sex marriage applied whenever at least one member of the union was a Spanish resident (*Boletín Oficial del Estado* 2005). Two non-residents cannot obtain a wedding license (as was common practice in Canada for United States citizens) but so long as one member is a resident, they may get married. Neither must be a Spanish citizen.

In an investigation of the state of marriage post-marriage equality, a study found that marriage equality had been successfully implemented into the state (Rickard 2012). Access to marriage is equal, making it easy for same-sex couples to obtain marriage licenses. While the Catholic Church has worked extensively to stop equal access, it has appeared to have failed. An average of 2,225 same-sex marriages have taken place over the last four years according to Spanish census data.

Same-sex marriage is extended to all residents of Spain and the marriage is in all legal ways equal. All benefits are extended to same-sex spouses, as are all rights and privileges. Employers are required to extend benefits to spouses. Marriages from outside of the country are recognized as lawful marriages and trans people are included in marriage equality. Despite efforts to repeal the law, 66% of citizens support same-sex marriage and 88% indicate they support LGBT rights. Religiosity, which will be addressed later, is strong in some sects, but LGBT culture and marriage is widely accepted in Spain. For these reasons, Spain scored a 10 in the level of marriage equality.

Laws Regarding LGBT Populations

Similar to Canadian efforts to eliminate systemic homophobia, many laws regarding LGBT populations were passed prior to recognition of marriage. Those laws that were not already accepted were passed at the same time as the same-sex marriage bill. This system is likely in part due to the widespread popular support for LGBT rights. 88% of citizens in the country support LGBT equality in some form, the highest in all of Europe (*Global Acceptance of Homosexuality* 2013). As of 2015, the only limitation in regards to LGBT laws is the inaccessibility of surrogacy options for gay men.

Adoption and Child Rearing

Spain recognizes same-sex families and has a variety of methods for producing a family for these couples. Spanish couples have access to step and joint adoptions and equal access to in vitro fertilization. The only limitation is that surrogacy is illegal, which limits gay men to adoption. Surrogacy, however, is not only illegal for gay men; it is illegal across the board, as Spain does not recognize a woman's right to renounce the child as hers (*Sobre la Gestación Subrogado* 2013). Unfortunately, this law severely limits a practice commonly used by gay men elsewhere to have families. Otherwise, no adoption agencies are legally allowed to turn away same-sex couples and access to in vitro fertilization is available to lesbian couples. The law regarding surrogacy has been evaluated critically and many believe it is a product of religious influence (Navas 2014). Many consider it a form of discrimination, not only to gay men, but also to infertile women. Many couples outsource to other countries, such as the United States to find a surrogate.

Anti-Discrimination Laws

Anti-discrimination laws have largely been in effect since 1996 with the passage of a series of laws that extended equal protection to LGBT populations. These laws added protection in terms of employment, provision of goods and services, and protection from hate speech, hate crimes, and indirect discrimination (*State Sponsored Homophobia* 2013). The workplace must extend all privileges to the spouse. Employers may not discriminate by using orientation as a basis for promotions, job changes, or firing. LGBT individuals may not be denied services on the basis of the orientation, and no company can deny sale on this merit. It is illegal to engage in physical or verbal harassment and LGBT related hate crime is documented and charged on this basis (*State Sponsored Homophobia* 2013). LGBT individuals also have the right to sue or press

charges if they feel any of these protections have been violated. LGBT people have been allowed to serve in the military since 1979 which predates many of the other anti-discrimination laws.

With passage of the marriage equality bill, LGBT individuals have been allowed to donate blood since 2005, including MSM and women how have sex with men who have sex with men.

Privacy and Identity

Same-sex sexual activity has been legal since 1979 as was the establishment of equal age of consent (*State Sponsored Homophobia* 2013).¹⁷ Since then, most citizens and politicians agree that sexual activity is not under the jurisdiction of the government. The Catholic Church, with a pervasive and influential force in Spain, largely rejects the opinion that sexual activity is outside of the realm of the government. They frequently argue that the government should actively prohibit sexual activity (Moscoti 2010). Fortunately, none of their efforts have proven fruitful in the political sphere. The age of consent is equal and same-sex activity is legal.

Transgendered individuals are legally allowed to change their sex on official documents. They are allowed to do so without sex reassignment surgery. In 2006, these laws were passed to protect transgendered people from the overmedicalization of gender (Platero 2011). Spain's efforts to validate trans identities and offer full-scale legal protection and recognition is unique. Legally recognizing the preferred identity is often met with a prerequisite of having had sex reassignment surgery or having had lived as the preferred gender for a set period of time (Platero 2011). There are some weaknesses in the system, as described below, but it is certainly further along than most countries.

¹⁷ In some countries, the age of consent for heterosexual couples is lower than the age of consent for homosexual couples.

Legal protection in Spain is quite protective of LGBT populations. With strong antidiscrimination laws, laws protecting their right to start a family, and laws relevant to privacy and identity, Spain is in the top of equality in a legal sense. Access to surrogacy is the only limiting factor, which gives Spain a score of 9.

Rate of Hate Crimes

Spanish authorities published a report of hate crime statistics separated by geographic location and by type of hate crime. The table represents the first half of 2014. This table was compiled from police reports documenting hate crimes (Terradillos 2014).

Figure 3: Rate of Hate Crimes in Spain

INCIDENTES RELACIONADOS CON DELITOS DE ODIOS CONOCIDOS POR GC, CNP, PFN Y PL (datos enero-junio 2014)							
	ANTISEMITISMO	APOROFOBIA	CONTRA LAS CREENCIAS O PRÁCTICAS RELIGIOSAS	DISCAPACIDAD	ORIENTACIÓN O IDENTIDAD SEXUAL	RACISMO Y XENOFOBIA	TOTAL
ANDALUCÍA	1	3	4	30	93	35	166
ARAGÓN	1	2	2	0	14	2	21
ASTURIAS (PRINCIPADO DE)	0	0	0	3	13	2	18
BALEARIS (ILLES)	0	0	0	6	24	3	33
CANARIAS	0	1	1	3	7	8	20
CANTABRIA	0	0	1	0	0	6	7
CASTILLA - LA MANCHA	1	3	0	4	5	14	27
CASTILLA Y LEÓN	2	4	2	11	12	6	37
CATALUÑA	0	0	0	0	3	1	4
CIUDAD AUTÓNOMA DE CEUTA	0	0	0	1	1	1	3
CIUDAD AUTÓNOMA DE MELILLA	1	0	0	0	1	1	3
COMUNITAT VALENCIANA	1	5	2	27	19	13	67
EXTREMADURA	0	1	0	2	2	4	9
GALICIA	1	0	1	25	22	4	53
MADRID (COMUNIDAD DE)	11	10	1	10	10	16	58
MURCIA (REGION DE)	0	1	0	2	7	1	11
NAVARRA (COMUNIDAD FORAL DE)	0	0	2	0	1	7	10
PAÍS VASCO (*)	0	0	0	0	0	0	0
RIOJA (LA)	0	1	0	0	1	0	2
Fuera de España	0	1	0	0	0	0	1
TOTAL	19	32	16	124	235	124	550

The table shows that hate crimes disproportionately affect LGBT individuals. Out of 550 reported hate crimes, 235 (43%) were motivated by sexual orientation or gender identity. 235 cases is nearly two standard deviations away from the expected value which indicates it is

disproportionately affecting LGBT individuals in some way. The second highest are disability and racism/xenophobia each at 124 reported cases or 22.5%, which is exactly half of the cases, reported for orientation and gender identity.

In 2013, police reported 1,168 cases of hate crimes, 452 (39%) of which were motivated by bias against LGBT people while racism/xenophobia stood at 32% and 24% respectively. This wide range of data indicates that reporting is likely inconsistent, but recent data for the past five years shows the same trends with LGBT people always being the highest percentage of the hate crimes (*Hate Crime Reporting: Spain 2013*).

Hate crimes in general are lower in Spain than in several of the other countries, however, they disproportionately affect those in the LGBT community. This bias indicates a degree of social homophobia and stigma that is indicative of structural violence. Spain received a score of 8 in this category due to a consistent trend in LGBT hate crimes.

Medical Understanding

The Spanish medical governing body, the General Council of Official Colleges of Doctors (CGCOM), and the Ministry of Health each publish a report on their ethics, ideology, and opinions. The Ethics Code published on the CGCOM website reports in Article 52 that doctors are strictly forbidden from taking sexuality into consideration when treating a patient. In other words, it is unlawful to deny treatment to a patient on the basis of sexuality. The article also reports that doctors may not discuss their opinions on sexuality when meeting with a patient. Physicians must also tell all patients, including LGBT couples about reproductive and family planning options. Article 51 dictates that physicians must inform all patients of the risks of STI's

(*Código de Ética Médica* 2011). The advised medical curriculum also includes necessary coverage of LGBT health.

The Ministry of Health publishes their opinions, reports, and advice on Gender Based Violence, and Families and Infancy. Gender Based Violence discusses trans violence specifically as a form of gender based violence (*Gender Based Violence* 2012). Under Families and Infancy the Ministry discusses same-sex parenting and shares their opinion that there are no risks or harms incurred in families with same-sex parents (*Families and Infancy* 2012).

The Spanish psychological governing body, the Colegios Oficiales de Psicologicas similarly publishes a Code of Ethics. Article 10 reports that no psychologists may discriminate based on any factor including sexual orientation. Article 37 dictates that psychologists must ensure the safety and privacy of all participants and patients, particularly as it relates to sexual orientation and behavior (*Code of Ethics* 2012).

While the discussion regarding LGBT individuals in Spain is less explicit than Canada or the United States, the codes of ethics and curriculum do not discuss LGBT populations in terms of pathology. They are adequately covered and protected by the medical community. The medical community addresses LGBT health issues and includes the LGBT community in discussion of topics that pertain to LGBT culture and topics that apply to the Spanish population in general. They exclude pathology or deviance and no treatment options are highlighted or emphasized. For this reason, Spain received a 10 in Medical Understanding.

Sex Education

The Catholic Church has retained a strong hold over the level of sexual education in the Spanish state. In the name of protecting the youth, the church has strongly influenced policy in terms of what should be taught in school regarding sex. The primary form of sex education in Spain is abstinence, which reflects the church's belief that abstinence is the only acceptable form of birth control. The country has no official program or state regulated curriculum. Many schools choose to bring in external programs and many omit sex education altogether (Venegas 2013).

Teachers in Spain feel that there are many obstacles in implementing quality sex education. Many feel that the schools or the districts do not consider sex education a priority and that there are not enough resources or funds to implement a better system. Many also feel they are not properly trained enough to teach a lesson themselves (Martinez 2012). These obstacles are systemic ways in which the church and the government can ensure that people do not receive quality information about birth control, condoms, and safe sex. Teachers without training in sex education were likely to bring in external programs, most of which push abstinence.

With an abstinence-centered curriculum, there is no room for sex education regarding LGBT individuals. LGBT sexual health is omitted entirely in most cases. Curricula only discuss LGBT health in reference to STIs and HIV. These reasons justify a score of 7.

Religiosity

A recent report indicated that one fifth of the Spanish population attended church at least once a week although a majority of the country identifies as Roman Catholic. This number has been steadily decreasing as less of the population strictly adheres to the policies of the church (*Barómetro de octubre* 2014). The history of Spain with the Catholic Church gives context to the current relationship between the two. After hundreds of years of complete control, then several

decades of complete isolation, the Church built itself a strong position in the current government. Throughout the early 20th century, different regimes pushed the Catholic Church out of influence. The dictator Franco, however, used the Catholic religion as a justification for his ruling and his actions establishing a firm connection to the Church, one that has persisted through today (Cassanova 2010: p. 108).

The Catholic Church has been rife with discontent surrounding several of the key decisions the Spanish government has made recently. The incumbent People's Party has worked to appease the Catholic Church by reversing key decisions made by the previous liberal government. While same-sex marriage has been legal in Spain for nearly ten years now, efforts are still made to repeal the law and define marriage as a union of one man and one woman. The People's Party opposes legislature that expands access to safe abortions. The People's Party was in power until 2004 and returned to power in 2011. Key decisions regarding LGBT health and safety were passed from 2005-2009. Since returning to power, the party has actively tried to repeal all of these key decisions. They have also cut funding for many programs and NGOs that protected LGBT populations as well as programs centered on sex education and HIV prevention methods (Wisler 2012). The People's Party is officially affiliated with the Catholic Church as a Christian democratic party.

The official position of the church and state is that the state must consider the religious beliefs of Spain and must therefore retain a cooperative relationship with the Catholic Church. While this grants the Catholic Church no formal power, it leaves the church in a key position for influencing policy makers and politicians, particularly in the People's Party. This strong influence indicates a score of 5 for Spain.

Visibility

Spain has a number of prominent LGBT figures and characters. Spanish television, particularly soap operas, have introduced LGBT characters and explored their storylines in and out of the context of their sexual orientation. There have been at least five LGBT politicians in Spain, including a transgender woman, Carla Antonelli, who works to improve information and legislation regarding transgendered people.

There are a variety of public events that support LGBT culture. Madrid has one of the largest gay pride parades in the world. The Colectivo de Lesbianas, Gays, Transexuales, y Bisexuales de Madrid (COGAM) is a prominent NGO that works to improve access to information and expose the population to LGBT culture. They serve as a resource on all LGBT subjects and work to improve visibility of prominent figures.

Spain has no out LGBT athletes in any public arena, including football or the Olympics. This may be in part due to hypermasculinity and machismo in Spanish athletic culture. Despite widespread efforts to eliminate homophobia in the country, this effort appears to have missed athletic culture. It is commonplace at sporting events to chant “maricón” which is a gay slur in Spanish. These factors make it difficult for LGBT athletes to come out in Spain.

Spain has made efforts to make LGBT culture visible. While representation is far from equal, LGBT culture has been incorporated more and more into mainstream media and society which indicates a score of 8.

HIV Infection Rates

The following charts outline the transmission of HIV and chlamydia in Spain. HIV transmission rates come from AVERT estimates in 2012 and chlamydia statistics come from independent, privately funded research (Fernandez 2013).

Table 5: HIV and Chlamydia Infection Rates in Spain

	HIV	Chlamydia
Prevalence	.4% (18,908)	4% (1,890,800)
Incidence	.0018% (851)	.9% (425,430)
Trend of Incidence	Decreasing	Increasing

Figure 4: HIV and Chlamydia Prevalence in Spain

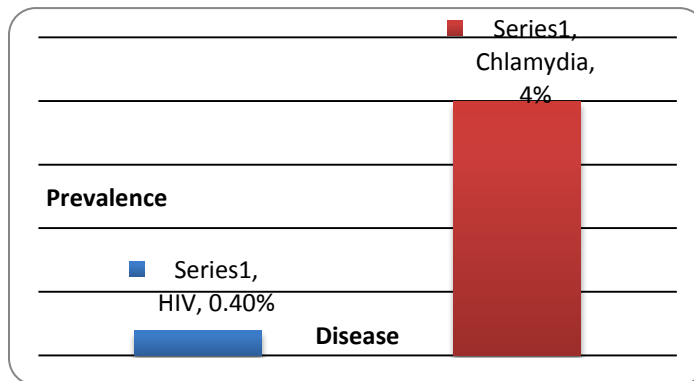
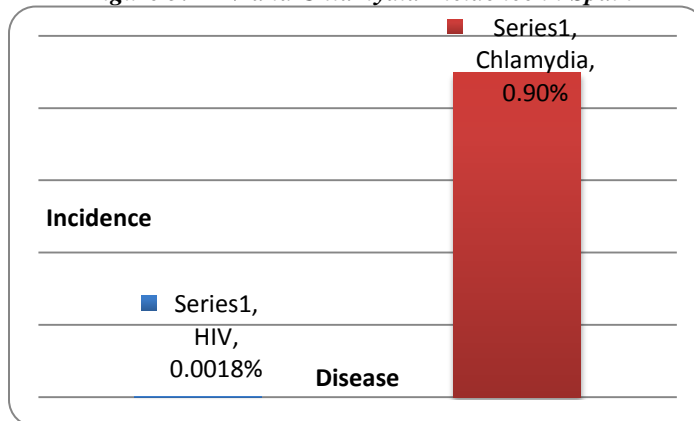


Figure 5: HIV and Chlamydia Incidence in Spain



Conclusion

Similar to Canada, Spain has made significant progress in eliminating homophobia, particularly in the last ten years. Their efforts are not perfect and their relationship with the Catholic Church limits the progress they could make. With 20% of the population identifying as strictly Catholic and with the conservative People's Party in power, it is unclear how much progress will continue in the future. Religious influence is pervasive, as evidenced by the People's Party and their continued efforts to repeal longstanding progressive legislature. Sexual education is severely limited in Spain, another unfortunate side effect of their religious history. Machismo and hypermasculinity limit LGBT visibility within the athletic arena. While marriage equality and LGBT legislature are extensive and provide coverage, protection, and safety to LGBT people, more efforts must be made to normalize the culture and eliminate social and systemic homophobia.

UGANDA

Introduction

Uganda rose to prominence in the news in recent years with its radical Anti-Homosexuality Bill. The bill would criminalize homosexuality in a very broad sense, punishable by life in jail. Debates surrounding the bill pervaded not only the country, but also the international discourse. Western countries condemned the bill as a violation of basic human rights. Early drafts of the bill pulled for the death penalty as a justified punishment for homosexuality. Though widespread dissent was common in the Western world, Ugandans widely supported the bill. Uganda is the lowest scoring country in the study as outlined below. Though HIV rates are significantly higher throughout Africa, the role of homophobia has yet to be evaluated.

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	1
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal- no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	1
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	1
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	3
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	5
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	3
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	2

			more accepted			
Total						16/70

Table 6: Operationalized Homophobia in Uganda

Level of Marriage Equality

Uganda does not support same-sex marriage, nor does any recognition of same-sex couples exist. In 2005, Uganda became the second country worldwide to expressly forbid same-sex marriage (*Uganda Constitution 2005*). This law has persisted and led to many additional laws that have severely limited LGBT equality and increased systemic homophobia. Uganda prohibits civil unions thus limiting any recognition of same-sex couples. No legal benefits are extended, and marriage licenses from outside countries are not recognized. These factors indicate a score of 1 for Uganda.

LGBT Laws

Uganda actively incriminates homosexuality and LGBT culture. Same-sex sexual activity is illegal in any form. LGBT people are not protected from anti-discrimination in any form. Employers may fire them for their orientation, companies may deny services or products on the basis of orientation, and there is no recognition of hate crimes. LGBT people are legally allowed to be targeted and assaulted. Any efforts to pursue charges are often limited and shut down early on in the case. Few, if any, convictions take place against offenders. Same-sex couples are not allowed to have families. There is no access to in vitro fertilization or surrogacy. They may not adopt children, nor can one member adopt a stepchild of their partner. LGBT Ugandans are not allowed to serve openly in the military. Blood donations from LGBT people, particularly MSM, are not allowed. Trans individuals do not have the right to change their legal gender and there is no recognition of gender identity (*State Sponsored Homophobia 2013*).

Uganda actively incriminates same-sex couples and homophobia is incredibly systemic in the country. While the Anti-Homosexuality Act in Uganda is on hiatus until further discussion, Uganda's government actively seeks legislation that incriminates homosexuality. If enacted, the

Anti-Homosexuality Act will give the government unrivalled power over LGBT culture. The Ugandan government already passed the bill and the president signed it into law. It is currently on hiatus due to a technicality and is likely to be reinstated once the government can vote on it again. This bill will make same-sex activity punishable by life in jail. The law also gives the government the power to fine companies or groups that support LGBT rights. The law has had widespread support within the country despite backlash around the world.

These factors indicate a score of 1 in LGBT laws.

Hate Crimes

Uganda provides no protection to LGBT individuals on the basis of hate crimes. Assault or attacks based on sexual orientation or gender are not recognized as a form of hate crime. Specific data is difficult to obtain considering the government does not finance any form of research or data collection that would indicate the high levels of hate crimes that exist. External research finds incredibly high levels of hate crimes, particularly against LGBT people (All Africa 2014, Clark 2014). These acts include battery, assault, arson, destruction of property, and death (Desrus 2011).

All Africa reports that LGBT people in Uganda report high levels of attacks, particularly throughout the discussion of the Anti-Homosexuality Act. There has been a reported surge in violations and targeted attacks on the basis of sexual orientation and gender identity (All Africa 2014). Some reports have indicated a 750 to 1900% increase in attacks since the introduction of the law (Bowcott 2014). This discrimination has sparked particular interest in the health risks of LGBT people in Uganda. Recent research shows that this increased level of hate crimes is linked to increased HIV transmission (Clark 2014).

Given the high rates of violent crimes, the lack of internal documentation, and a complete disregard for targeted violence, Uganda received a 1 in Hate Crimes.

Medical Understanding

The Ugandan President Yoweri Museveni hesitated on signing the Anti-Homosexuality Bill, indicating that he would need medical evidence that homosexuality was a choice in order to enact the law. He turned to various organizations both internal and external, asking for justification for their claims surrounding homosexuality, including asking the United States for evidence that homosexuality was genetically predisposed. Despite the US offering a variety of reports, including public opinions of the AMA and APA, Museveni turned to his own medical experts who cited such examples as bisexuals and prison inmates as evidence of choice in homosexuality. While the study repeatedly reports that sexuality is a product of genes, society, and environment, it ultimately concludes that homosexuality is not controlled by genes, should be regulated, and is a flexible, dynamic characteristic that can be changed and regulated if need be (Ministry of Health 2014). There is discussion of choice, deviance, and lifestyle in the report. The report claims that because homosexual people cannot reproduce they must “recruit and inculcate” children (Ministry of Health 2014). It claims that in response to the questions about whether homosexuality can be learned and unlearned, the answer is yes. Although it expressly states that homosexuality is not abnormal, the president wanted genetic evidence if he were to reject the bill. As the report indicates that homosexuality is a choice in some manners, it ultimately weakened the argument against the bill (*Uganda Scientific Report on Homosexuality* 2014). After this investigation, Museveni signed the law, indicating there are medical and

scientific bodies in Uganda who believe homosexuality is a choice and deviant (*Ugandan Leader Signs Anti-Gay Bill* 2014).

Surprisingly, the Ugandan Minister of Health has publicly announced that healthcare, particularly as it pertains to HIV is available to all people. He stated that all people are covered and should be protected in healthcare. This position is surprising considering the current conditions and because the government actively seeks out LGBT people to incriminate. This position is likely in response to the incredibly high HIV rates in Uganda. The Minister, Ruhukana Ruganda, has made it clear that the hospitals and doctors must retain privacy when dealing with sexual orientation and will not report them to the government on the basis of medical safety (Ruganda 2011 BBC News).

Conversion therapy is widely used in Uganda as an acceptable form of treatment for sexual deviance and while the Ministry of Health and the Uganda Psychological Association make no endorsement of conversion therapy, neither has published literature discrediting it.

Uganda scored a 3 in medical understanding. Despite no official stance by the medical bodies in Uganda, widespread belief that homosexuality is a choice, deviant, and should be corrected exists, including within the scientific and medical community.

Sex Education

Uganda has adopted a statewide abstinence-only sex education program. The state must approve all programs and these programs all emphasize abstinence as the primary form of birth control and protection despite the fact that research has shown that these programs do not alter adolescent behavior, do not delay sexual initiation, nor do they reduce rates of pregnancy or STI's (*Human Rights Watch* 2005, *Advocates for Youth* 2013).

Uganda widely accepts the use of the AB program, formerly ABC, or Abstinence, Be Faithful, and Use a Condom. Uganda has in recent years dropped the C and focused entirely on abstinence until marriage and abstaining from extramarital sex. Ugandan officials felt that teaching about condom use while simultaneously teaching that there should never be a use for one was contradictory and undermined the importance of abstinence.

The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) is a similar program in elementary and middle schools that emphasizes abstinence. The program is partially funded by the United States Center for Disease Control and Prevention. The program emphasizes abstinence until marriage and condom use after marriage to stem HIV infection (*Human Rights Watch* 2005).

Social sex education is also common. The “senga” or father’s sister is a source of sex education within the community for adolescent girls (Muyinda 2004). Sengas are tasked with socializing girls about sex, marriage, and their responsibilities in a relationship. Community based systems such as these can be problematic as they reinforce the status quo. There is also no formal training to become a senga, it is simply the responsibility of the father’s sister to educate all of the women (Muyinda 2004). Without formal training, it is common to have dissemination of false information and access to proper HIV protection is limited. Efforts to modernize sengas has proven to be effective; sengas educated about HIV and birth control disseminated this information within their community (Muyinda 2004). Because sex education is often taboo and abstinence-only programs are commonplace within Uganda, training sengas on modern sex education may prove to be an effective form of implementing sex education within Uganda.

The discussion of HIV and abstinence-only programs indicate a score 5 for Uganda in sex education.

Religiosity

The current ruling party in Uganda is the National Resistance Movement. This party has no formal connection to any specific religion and discussion of the Catholic Church is not found in the description of the party. However, the National Resistance Movement proposed the original form of the Anti-Homosexuality Act. Justification for the AHA has largely turned to religious convictions. The National Resistance Movement commonly uses Christian Fundamentalism to justify decisions and the argument for the AHA has been rife with Christian extremism (Harris 2012). The bill itself was partially drafted by American pastor Scott Lively. The National Resistance Movement and the powerful elite use Christian fundamentalism as a coercive tool to shape Ugandan policy (Harris 2012). Many political officials including President Museveni and the author of the bill Bahati are also members of The Family, an organization that uses financial and political connections to further God's kingdom.¹⁸ The connection with The Family within the Ugandan government indicates a strong relationship between Christian Fundamentalism and Ugandan policy. The conservative agenda is rife with arguments of morality and backed by religious justifications (Muller 2014).

Religious adherence is high within Uganda particularly as justification for beliefs. Religious convictions have a strong influence on the beliefs that Ugandans hold. 65% of Ugandans agree with the statement that HIV/AIDS is God's punishment for immoral sexual behavior (The Pew Forum 2010). Similarly, 69% believe sex between two unmarried people is

¹⁸ The Family is an American centered organization. The president is Senator Tom Coburn (R-OK) who has been cited as saying "the greatest threat to our freedom today are gays who have infiltrated the very centers of power" (Harris 2012).

morally corrupt and 79% of Ugandans believe homosexuality is morally wrong (The Pew Forum 2010).

A high level of religiosity is also paired with noncompliance to antiretroviral treatment. Many who consider themselves very religious stopped taking ARTs, believing that medicine was testing God's plan (Tumwine 2012, Kisenyi 2013). This poses a risk as those who may otherwise be undetectable have high viral loads and may pass on the virus to children or partners.

These factors justify a score of 3 for Uganda.

Visibility

LGBT visibility in Uganda is incredibly limited for a variety of reasons. Primarily, it is incredibly dangerous to be openly LGBT. LGBT people are targeted and often victims of assault and murder that most often goes undocumented or without charges. In recent years there have been many LGBT and pride demonstrations, protesting the Ugandan government and the Anti-Homosexuality Act. While there is widespread support for the law both in the government and socially, small groups come together to protest the bill and the government.

Uganda actively blocks LGBT portrayals. Media is not allowed to show same-sex couples or activity; television shows depicting LGBT characters are blocked. Mocking LGBT culture is allowed although any portrayals are uncommon. Prominent figures are unlikely to come out as they will be vilified, mocked, and even targeted for attacks.

Uganda receives a score of 2 because there are small, organized groups hoping to change the tide (Sexual Minorities Uganda). There are very few LGBT representations and all are mocked. The government blocks portrayal of LGBT culture and high profile LGBT figures are nonexistent.

Infection Rates

The infection rates in Uganda are incredibly high. There are just as many new cases every year in Uganda as there are total cases of HIV in Spain. Chlamydia rates are not available for Uganda, though STI infections in general occur at very high rates and appear to be increasing. HIV data was obtained through AVERT (*HIV & AIDS in Uganda 2012*).

Table 7: HIV and Chlamydia Infection Rates in Uganda

	HIV	Chlamydia
Prevalence	7.1% (2,668,180)	*****
Incidence	.4% (150, 320)	*****
Trend of Incidence	Increasing	Increasing

Conclusion

Uganda's systemic homophobia is very high as evidenced by a composite score of 16. There are as many new cases of HIV in Uganda every year as there are total cases in Spain. Despite widespread efforts to eliminate HIV and international interventions working with Uganda to prevent transmission, the incidence and prevalence of HIV remain incredibly high. Uganda may very well illustrate the failures of HIV prevention programs. With an emphasis on abstinence-only programs and rampant homophobia, Ugandan policy and prevention programs fail to address MSM and GBT populations. By targeting and incriminating LGBT people, Uganda may very well facilitate increased risk situations. LGBT people will continue to exist in Uganda despite their legislation and with no resources, no prevention or protection programs, placing GBT people in risk situations will make riskier decisions, simply increasing the problem.

With limited understanding of HIV and its mechanism prevalent within Uganda, targeting LGBT populations will only reinforce the idea that HIV is a “gay disease.”

RUSSIA

Introduction

Similar to the case of Uganda, the matter of homophobia in Russia rose to international attention at the proposal of the Anti-Propaganda Bill. The discourse of the bill indicated it as a protective measure for children and traditional families; however, the bill broadly defines propaganda and in its truest applications is a justification for the criminalization of homosexuality. With international and internal resistance and attention, the bill has highlighted the homophobia systemic in the country, as outlined below. Russia is the second lowest scoring country with the second highest HIV rates in the study.

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	1
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal- no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	6
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	1
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	4
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	2
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	4
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	2

			more accepted			
Total						20/70

Table 8: Operationalized Homophobia in Russia

Level of Marriage Equality

Russia has no provisions for same-sex marriage or civil unions. Marriage licenses are not available and there is no recognition of civil unions. Article 12 of the Family Code¹⁹ strictly prohibits same-sex marriage, stating that marriage is the union between one man and one woman. No legal benefits are extended to same-sex couples. Public opinions and poll research shows that a large majority of the Russian population opposes legal recognition with only 5% of responders indicating they support same-sex unions. There is current debate as to whether or not marriages from outside countries are recognized; however, currently there are no federal benefits extended to these couples. For these reasons, Russia scored a 1 in Marriage Equality.

LGBT Laws

Russian legislation regarding LGBT equality are varied and create an inconsistent pattern, unlike many other countries. These laws and inconsistencies are outlined below.

Adoption and Child Rearing

The Family Code in Russia dictates that only married couples may adopt a child, thereby prohibiting same-sex couples due to their inability to get married. Strangely, legislation in Russia also allows single individuals to adopt a child. In this case, therefore, it is not illegal for an LGBT person to adopt a child. The Russian government requires those pursuing this route of adoption to undergo rigorous court examinations, investigations, and checks. Though there is no legislation indicating that LGBT individuals may not adopt in these means, LGBT individuals have reported that the courts often consider links to the LGBT community in their decision.

¹⁹ The Family Code is the category of laws pertaining to marriage, divorce, raising children, and the rights and duties of parents in Russia.

Russian use of ART is wide and has established a market for fertility tourism in which couples from other countries travel to Russia in order to take advantage of the wide access to surrogates and in vitro fertilization. There are very few limitations on these procedures in Russia, which attracts couples from across the world who need this technology to start a family. The provisions of the Family Code still apply and companies providing ART must ensure that only married couples and single individuals may use the technology. Legislation drafted in 2013 worked to actively ban surrogacy to LGBT couples. Currently, however, gay men are legally allowed to use a surrogate provided they are single (Svitnev 2010). Discrimination based off of sexuality, however, is common.

The Russian government has also banned adoption of Russian children by same-sex couples outside the country. In other words, a same-sex couple in the United States cannot adopt a Russian child.

Anti-Discrimination Laws

Russia provides no legislation extending protection to LGBT individuals. Employers may fire or choose not to hire an individual based off of sexual orientation. Similarly, employers may use sexual orientation when considering promotions or pay raises. Businesses have the right to deny services or goods to LGBT individuals. Crimes against LGBT individuals are not considered hate crimes and legislation provides no protection to victims of targeted crimes. Similar to the case in Uganda, the lack of protections mixed with heightened public interest has sparked increased levels of hate crimes, as discussed below. Authorities have noted that they do not believe there is a need for protection from discrimination and that individuals should have the right to deny services to those they deem immoral.

Privacy and Identity

Privacy and identity laws are one strength in Russia. Same-sex sexual activity has been legal since 1993 and Russia maintains an equal age of consent in that same-sex and opposite-sex activity requires both partners to be at least 16 years of age. In 2008, the Russian Health Ministry ended the ban on MSM blood donations, thus allowing LGBT people to donate blood. LGBT individuals have been able to serve in the Russian military since 2003 although due to the lack of anti-discrimination laws, they may still legally be fired for being gay.

Transgender people have had the right to change their legal gender since 1997. Though this process is highly medicalized, fulfillment of criteria allows for transgender people to change their gender on passports and ID's.

Anti-Propaganda Law

The Duma, the lower house of the Russian legislature, unanimously passed the anti-propaganda legislation in June 2013 and Russian President Vladimir Putin immediately signed it into law. The Duma, Putin, and the many supporters of the law cite its purpose as to protect the “children from information advocating for a denial of traditional family values” (*Russian Family Code* 2014). The law, though widely criticized by Western nations, has received widespread support. At least 88% of Russian citizens support the law (All Russian Public Opinion Center 2014). The law specifically cites homosexuality as a deviant alternative to sexuality and bans all propaganda that children might be able to obtain. Propaganda is loosely defined and includes any form public support for LGBT culture. The law bans all LGBT symbols, parades, information, and meetings from public display. Infractions of the law incur high fines and jail time. The broad wording of the legislation creates a system that effectively eliminates LGBT culture from the public eye, punishable by law. Legislators and citizens have used the law as justification for hate

crimes and LGBT people must effectively hide their culture to avoid the loose definitions of propaganda cited in the law. Though the law cites the protection of children as a justification for its harsh penalties and loose definitions, the law is truly a tool to persecute and eliminate LGBT culture within Russia.

The LGBT laws in Russia are complex and at times, contradictory. Despite widespread social homophobia, Russian legislation recognizes same-sex sexual activity as legal, allows transgender people to change their legal gender, and allows single LGBT people to adopt. Discrimination, however, is widespread and Russian legislation provides no protection against it, with public figures stating that there is no need to protect LGBT people from discrimination if the discrimination is credible. Russia scored a 6 in LGBT laws because there is no active incrimination of same-sex activity but there are also no protections granted.

Rate of Hate Crimes

The lack of identification of LGBT targets as a hate crime creates an inherent limit in the studies that report hate crimes. Efforts to investigate hate crimes are limited. The ban on LGBT propaganda bans newspapers and other media sources from highlighting violence against LGBT individuals. Similarly, the police do not label crimes as hate crimes if the motivation was due to sexual orientation. This creates an environment in which hate crimes motivated by sexual orientation are widely underreported. Victims of hate crimes are also unlikely to report their crimes for fear of public knowledge that they are LGBT.

Regardless of a lack of reliable statistics, these hate crimes are estimated to be incredibly high. Those crimes that are identified are incredibly gruesome and violent. National attention is common due to the widespread attacks and the nature of the crimes. LGBT individuals are

directly targeted and violently attacked due to their sexual orientation. The Human Rights Watch, an international non-governmental organization has taken particular interest in recording the status of these hate crimes in Russia. Through quantitative and qualitative research, they were able to publish a report entitled *License to Harm* that records the nature and number of these crimes. Of the attacks they investigated, only three were brought to the court and only two were prosecuted. The attackers did not receive a punishment that matched the gravity of their crimes (*License to Harm* 2014; p. 2). The study also found what many reports already knew- victims of these crimes were exposed and not adequately protected. The study found a high degree of re-victimization. The government response has been insufficient and efforts to stop the rise in attacks are dismal. Most of the perpetrators of these crimes are either immediately released or only detained for a short time (*License to Harm* 2014; p. 3). Many victims of the crime were also detained and were in many cases just as likely to be charged and prosecuted for involvement in a public disturbance (*License to Harm* 2014; p. 6). Vigilante groups are highly involved in these attacks and cite the anti-propaganda law as justification for their attacks (*License to Harm* 2014; p. 6). The unjustified but incredibly common perceived link between homosexuality and pedophilia is also a common justification for attacks. A number of victims that pursued more prosecution retracted their statements for fear of re-victimization or public knowledge of their identity (*License to Harm* 2014; p. 7). One victim noted, “I’m scared to go to the police. I don’t trust them and doubt my complaint would be taken seriously and investigated. I knew it would be a waste of time. The [propaganda] law gave a green light to homophobes to attack us” (*License to Harm* 2014; p. 7). Attacks at public rallies are also prevalent and victims from these

attacks are more likely to be arrested, particularly since the passage of the anti-propaganda law. Victims have stated that they have been verbally abused, beaten, cut, and raped.

Though hate crimes such as these exist even in the least homophobic countries, the lack of response from the government and the sheer volume of attacks indicate that hate crimes in Russia are particularly prevalent. The nature and number of the crimes as well as the lack of response by authorities or the government establishes a score of 1 to Russia in terms of hate crimes. Despite widespread documentation of these crimes, the government continues to ignore them.

Medical Understanding

The Russian Health Ministry declassified homosexuality as a mental disorder in 1999 after adopting the ICD-10, published by the World Health Organization, which endorsed homosexuality as a natural behavior that cannot and should not be treated. Despite widespread criticism and popular belief that homosexuality is in fact a pathology, the Ministry of Health has stood by its decision stating that homosexuality is not a treatable condition. Conversely, the medical community appears to uphold the belief that homosexuality is deviant and pathological. Many have thus criticized the Ministry of Health, believing their opinion only eliminated pathology to appease Western neighbors. A 2014 study found that 63% of psychiatrists believe that homosexuality is an illness and 75% view homosexuality as immoral behavior (Savenko 2014). A 2002 effort to recriminalize homosexual acts found widespread support from doctors. A 2007 study also noted stigma by the healthcare system for fear of being labeled homosexual as one of the primary reasons for avoiding testing or treatment of HIV (Balabanova 2007). Research on nurses and the nursing education in Russia similarly found a high degree of

stigmatization and negative attitudes surrounding HIV and AIDS (Suominen 2015). The nurses analyzed had a high degree of homophobic attitudes and scored very low on tests about HIV (Suominen 2015). In terms of society's views, 43% of citizens view homosexuality as a mental disorder resultant from poor parenting, abuse, or lack of discipline (Levada Center 2014).

Harm reduction programs and NGOs targeting HIV and AIDS have been discredited and unfunded by the Russian government. One of the many reasons for the high rates of HIV in Russia is because of the lack of support from the medical community. Doctors turn away patients who are HIV positive (Pape 2014). NGOs who aim to lower HIV rates and risk are particularly targeted as the anti-propaganda bill ensures that these organizations cannot support or educate the community about LGBT culture or the risks of HIV as they pertain to same-sex couples (Pape 2014). The medical community still widely regards HIV as taboo and still attributes its spread in some capacity to LGBT individuals. Though HIV spread in Russia is largely linked to intravenous drug users, doctors and other healthcare providers often have a high degree of HIV stigma, attributing the disease to homosexual populations (Kelly 2014). These combined aspects create an environment in which the medical community does not adequately handle the epidemic of HIV in Russia. Due to these aspects, Russia scored a 4.

Religiosity

Due to the history involving the Soviet Union and the longstanding conflict between the Russian Orthodox Church and the government, religious association and adherence is relatively low within the country. Due to the switch from the Soviet Union back to the Russian Federation, there has been a recent spike in return to the Orthodox church, although not in those who actively attend church (Greely 2004, *Russian Return to Orthodoxy* 2014). Though 41% of Russians

associate with the Russian Orthodox Church, only 11% actively attend church (SREDA 2014). Atheism and spiritual without religion are two prominent ideologies as well at 13% and 25% respectively (SREDA 2014).

Despite a variety of religions and a prominent group of atheist and spiritualists, homophobia remains prevalent throughout Russia. The majority of the population believes homosexuality is amoral, a belief rooted in Orthodox beliefs. The justification for homophobia often stems from the belief that homosexuality is immoral or socially deviant, linking homosexuality to pedophilia, incest, and bestiality (*Russia's Moral Barometer* 2014). Though the individuals may not practice the religion, religion is a widely used justification for homophobic legislation and actions.

The Orthodox Church maintains a strong association to the government. In 2012, Putin appointed a representative from the church to a governmental position. This provides the Orthodox Church immense influence over the decisions and legislation in Russia. The church also enjoys a high degree of autonomy within the country. Prominent Russian figures have also come out in support of the Orthodox Church (Davidashvili 2013). Putin and the Orthodox Church have cited homosexuals as the cause for declining populations and birth rates in the Russian state.

Due to the prevalence of religion and its link to the government, Russia scored a 4.

Sex Education

The Russian discourse surrounding sex, sexuality, and sex education frequently references children as cause for discrimination. Specifically, many lawmakers and supporters of the anti-propaganda bill cite protecting children as one of the reasons it is necessary. Putin specifically has said that the bill is essential to “protect the children” and that gays and lesbians are “full fledged members of our society (who are) not being discriminated against in any way” (Putin 2014). Similar arguments are pervasive in discussion surrounding sex education (Meylaks 2011). Advocates of sex education cited concern for the behavior of sexually active minors; opponents cited innocence, moral purity, and tradition as concerns for introducing sex education in schools (Meylaks 2011). Currently, the Ministry of Education and the Presidential Children’s Rights Commissioner ban sex education in schools and oppose its introduction. These bans have had harmful effects on the Russian population. Russia has a very high degree of STI infection, unwanted pregnancies, and sexual violence, all of which are particularly common in teenage and young adult populations (Shapiro 2001).

The Russian Orthodox Church also endorses sexual health educators who discuss sex and sexuality with adult populations. These organizations, aligned with the Church, are the only nationally recognized form of sex education. Their opinions, however, closely align with those of the church. These educators limit sex education to the boundaries of marriage, thereby creating an abstinence-only form of sex education for adults (Jackson 2005). Adults who take part in these sessions do so by choice and participants are drawn from the church as well.

Under the anti-propaganda law, the distribution of literature specific to LGBT individuals and safer sex practices is considered propaganda punishable by fine. While NGOs and other organizations may publish literature regarding safer sex, it must be specific to heterosexuality.

For these reasons, Russia scored a 2 in sex education.

Visibility

The anti-propaganda law inherently limits the degree to which LGBT culture is visible. After the decriminalization of same-sex activity in 1993, gay clubs and organizations became fairly common in the urbanized areas, particularly in St. Petersburg and Moscow (*Moscow Pride '06* 2006). Though Russian culture largely rejects LGBT people, these businesses illustrated a small but prominent group of LGBT people and supporters. This small group has tried to create an internal movement against the high degree of homophobia in Russia by organizing pride parades and public events to bring light to LGBT culture. Unfortunately, the Russian government and society have been largely unreceptive to these movements. Prior to the anti-propaganda legislation, public protests and local governments stopped LGBT gatherings and pride events. The documentary *Moscow Pride '06* highlights the history of oppression of LGBT culture (*Moscow Pride '06* 2006). Prior to the 2014 legislation, these events were legal and opposition only came from protestors and the cities and venues where they were held.

The anti-propaganda bill bans pride events including pride parades and marches. Since its passage, LGBT events have hidden behind the mask of human rights events. Human rights events and parades are not illegal but the majority of participants are LGBT or LGBT supporters. These events are a source of controversy and violence and arrests are common (*The Facts on LGBT Rights in Russia* 2014).

The 2014 Sochi Winter Olympics brought international attention to the law. The law allows provisions to the government to detain, fine, and export foreigners. This inhibited athletes from coming out or showing support for LGBT culture, an aspect that Olympic athletes and

Western authorities widely criticized. The Russian government, however, remained firm in its decision to uphold its legislation.

There is no representation or characterizations of LGBT people in the media as this would be considered propaganda. Similarly, there are no prominent figures or CEOs who are open about their sexuality. Though many have been open about their opposition for the law, there are no athletes, actors, or celebrities. Though prominent Russian historical figures such as Tchaikovsky were homosexual, the current cultural climate creates an environment impossible for LGBT people to be open and safe. For these reasons, Russia scored a 2 in LGBT Visibility.

Infection Rates

The prevalence of HIV in Russia is particularly high. Though HIV prevalence rates above 1% are common in African countries, they are very infrequent elsewhere. These infection rates have been of particular concern to organizations such as AVERT and the World Health Organization as the incidence and prevalence continue to increase every year, despite recommendations from external organizations. These increasing rates are of particular alarm as NGO's and other efforts to stem the infection rates have been eliminated, as discussed above. Data for HIV rates comes from AVERT and chlamydia rates are estimates from the World Health Organization (*HIV & AIDS in Russia 2012, Fact Sheet 2013*).

Table 9: HIV and Chlamydia Infection Rates in Russia

	HIV	Chlamydia
Prevalence	1.1%	15%
Incidence	.03%	.276%
Trend in Incidence	Increasing	Increasing

Figure 6: HIV and Chlamydia Prevalence in Russia

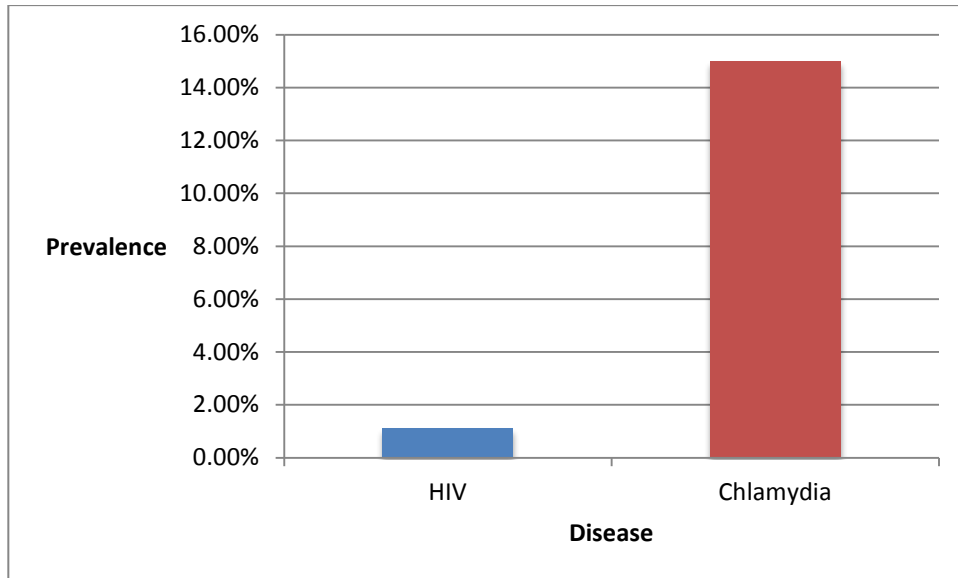
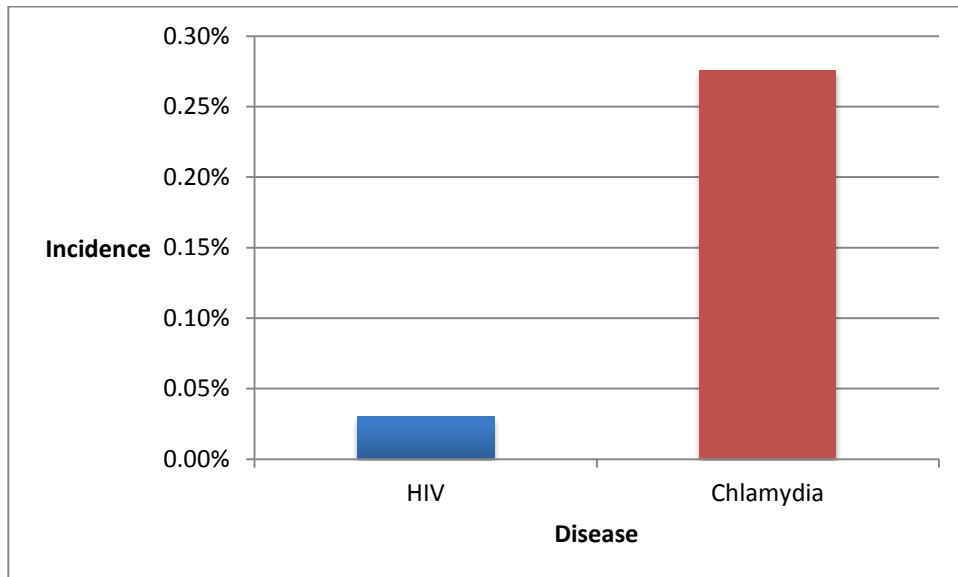


Figure 7: HIV and Chlamydia Incidence in Russia



Conclusion

Though HIV rates above 1% are far not uncommon, they are rare outside of Africa. The high HIV prevalence in Russia is cause for concern and further investigation. Systemic homophobia in the country limits access to HIV care from LGBT individuals. With the passing of the Anti-Propaganda bill, the situation will only worsen. Access to accurate information will become impossible to find, constructing violence against LGBT people in the country. Though the official medical opinion indicates a lack of pathology related to LGBT culture, the practice and application appear to be the opposite. Russia's rates of HIV are multifaceted; however, this investigation into homophobia specifically highlights structural violence endemic in the country.

UNITED STATES

Introduction

Efforts to accurately operationalize homophobia in the United States are complex. The country is vast and systemic homophobia varies by geographic location. Recent trends since 2011 indicate the growing acceptance of LGBT culture. Marriage equality has been the current focus in the country and progress has been swift, particularly since *Windsor v State*. Unlike several countries who legalized same-sex marriage before it, however, post-marriage equality United States will have significant progress to make in order to eliminate systemic homophobia. Discrimination is still prevalent and religiosity in the United States is incredibly high compared to other Western nations. Considering the recent trends in progress, however, the federal government appears to be more effective in eliminating systemic homophobia than allowing the states to decide for themselves.

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	8
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal- no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	6
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	7
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	9
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	6
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	5
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	9

			more accepted			
Total						50/70

Table 10: Operationalized Homophobia in the United States

Marriage Equality

Same-sex marriage in the United States is far more complicated than any other country in this study. Whereas other countries have federally recognized or rejected same-sex marriage, the matter has created a power struggle between federal and state governments in the US. Currently, 35 states²⁰ and the District of Columbia grant same-sex marriage licenses without further complication, providing 69.4% of the population access to marriage equality (Freedom to Marry 2015). A further three states, comprising 4.3% of the population, have access to same-sex marriage due to state recognition but widespread opposition has created barriers within these states that complicate or limit access. In Kansas, the District Court ruled that same-sex marriage was legal; however, very few counties have adopted this policy and government officials in Kansas have indicated their opposition and continued to enforce the ban in most counties (Freedom to Marry 2015). Specifically, the majority of counties continue to deny marriage licenses as the state government advises. The state government continues to deny state privileges that it offers to heterosexual couples, including changing the last name on state-issued identification cards, state tax benefits, and access to healthcare information (Freedom to Marry 2015). The Supreme Court and the Circuit Courts have denied a stay in Missouri, but same-sex couples have still reported being turned away when they apply (Freedom to Marry 2015). Similarly, the District Court of Alabama ruled that the courts must issue same-sex marriage licenses, however, strong opposition has led to various forms of complications culminating in the Alabama Supreme Court ordering judges to stop issuing same-sex marriage licenses (Freedom to

²⁰ Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Marry 2015). Various counties in several states have also opted to stop issuing marriage licenses altogether, rather than offer them to same-sex couples. These current events are not dissimilar to the situations the 35 states that offer licenses experienced. For example, resistance in Florida led to several contradictory statements. Areas such as Duval County opted not to offer marriage licenses at all until the District Attorney and other governing bodies made appeals. In five²¹ states the battle for marriage equality is awaiting a decision for an appeal from various Circuit and Supreme Courts. A final seven states²² have no recognition for same-sex marriages. States that have provisional or no access to same-sex marriage are localized to the Midwestern and Southern regions.

The strength of the United States marriage equality is three pronged. Firstly, despite the opposition by state governments, the trend thus far has indicated a pro-marriage equality stance by the federal government. All efforts to appeal or repeal marriage equality provisions have failed. Secondly, marriage equality is at the forefront of various political platforms. Though different political candidates hold a variety of opinions, candidates frequently discuss their opinions. This has provided unrivalled opportunity for pro-marriage equality organizations to raise awareness and educate. Even by publicly opposing marriage equality, candidates bring light to the issue. The case for this is justified by the dramatic change in public opinion in recent years. According to Gallup, a prominent poll based research organization in the United States, the majority of Americans support marriage equality (Gallup 2014). Support became the majority in 2011 and has stayed above 50%, steadily increasing ever since (Gallup 2011, 2012, 2013, 2014). Similar poles have also illustrated an upward trend in support for same-sex

²¹ Texas, Arkansas, Mississippi, South Dakota, Nebraska

²² Louisiana, Tennessee, Georgia, Kentucky, Ohio, Michigan, North Dakota

marriage (CNN 2015, ABC News 2014). Interestingly, opposition to marriage equality follows the same trend as the status of marriage equality; polls indicate lower rates of support. National attention and public discourse raised awareness and provided an environment where communication and discussion surrounding not only marriage equality, but LGBT equality in general, are admissible. Finally, and arguably most importantly, the federal government broadened the definition of marriage to cover same-sex couples through *United States v. Windsor*. The case struck down the Defense of Marriage Act as unconstitutional thereby providing federal benefits to all married couples. The federal recognition of same-sex marriage itself seems to have sparked the statewide revolution. Prior to the Supreme Court decision, marriage equality was only available in nine states.

Due to the complex nature of marriage equality in the United States, the US earned a score of 8 in the level of marriage equality.

LGBT Laws

Similar to the situation with marriage equality, the separation between the federal and state governments has established a murky state of affairs regarding LGBT laws. While the status of marriage equality has created an upswing in the discussion of other LGBT issues, very few states have adopted a broad policy that extends provisions and protections to LGBT citizens. Likewise, federal recognition of discrimination is limited. These inconsistencies and difficulties are outlined below.

Adoption and Child Rearing

The federal law provides no outline for adoption or child rearing policies. The majority of these policies are adopted at the state level. Joint adoption by a same-sex couple and access to commercial surrogacy by gay men are both legal in some states and explicitly banned in others. The federal government provides the states the power to define adoption policies as they see fit. Currently, half of the states permit joint adoption; however, only four²³ of the remaining states have adopted policies that explicitly prohibit same-sex adoption (Lambda Legal 2014). The remaining states provide no provisions thus it is up to the adoption agencies to decide whether or not they will allow same-sex couples to adopt a child (Liberty Council 2013). Many of these states also have additional requirements for same-sex couples that are not required for heterosexual couples. Discrimination in these states is prevalent. A majority of states do not allow single homosexual individuals to adopt (Liberty Council 2013). Access to commercial surrogates to gay men is equally split. Though about half of the states allow access, the vast majority of states have not created legislation relevant to the issue, leaving the issue murky (Lambda Legal 2014). Though organizations such as Lambda Legal and the Human Rights Campaign have made efforts to bring attention to these inequalities, focus in recent years has emphasized marriage equality as a priority. Efforts to increase LGBT equality in adoption and child rearing have largely been pushed to the side.

Anti-Discrimination Laws

Anti-discrimination laws are not dissimilar to the aforementioned laws. States have authority to increase discrimination as they see fit, so long as they do not infringe upon federally recognized human rights, which are limited to protections from violence as federal recognition of

²³ Florida, Michigan, Utah, Mississippi

LGBT targeted hate crime exists. Although marriage equality is available to nearly 70% of the American population, 29 states include discrimination laws that make it lawful to fire, deny services or products to, or otherwise discriminate against individuals on the basis of their sexual orientation or gender identity. There is no federal law protecting or providing rights to LGBT individuals in any of these arenas. It is lawful to deny access to housing and healthcare as well. In many states “gay panic” is a justifiable excuse for homicide (Lee 2013). MSM are not allowed to donate blood.

The repeal of “Don’t Ask, Don’t Tell” in the US established several key internal changes to the military. Men and women can no longer be fired for their sexual orientation and federal benefits, as well as military privileges have been extended to military same-sex spouses. The military has been widely praised for its swift shift from being aggressively homophobic to increasingly pro-equality.

Privacy and Identity

Several key cases established that bans against consensual sex between same-sex partners were unconstitutional (*Lawrence v. Texas* 2003, *State v. Limon* 2005). As of 2003, same-sex sexual activity is legal although the age of consent varies in differences by state.

Provisions to transgendered individuals vary widely. The vast majority of states do not recognize the right to change their legal gender. Even those states that provide access have severe limitations. The majority of states require transgendered individuals to undergo sex reassignment procedures in order to procure the legal gender change. No federal stance has been made. Transgendered individuals can be fired for their gender identity in 32 states. The majority of states do not allow transgendered individuals to use their preferred restroom.

The federal and state government split creates a unique situation in the United States for LGBT rights. The federal government has left the majority of decisions up to the states. Though marriage equality is available in well over half of the states, discrimination is still legal and prevalent in a majority of states as well. The federal government's recent more progressive stance has allowed for increased access to marriage equality; however, the lack of position has created a lack of effort to remove homophobic policies systematically. Though the majority of Americans believe anti-discrimination laws should be added, the emphasis in the United States is localized to marriage equality. Though other progressive countries such as Canada and Spain extended LGBT rights and equalities first and then adopted marriage equality, the post-marriage equality United States will have a variety of LGBT laws to debate in the coming years. The United States scored a 6 in LGBT laws.

Hate Crimes

The federal government of the United States extended coverage to LGBT populations in regards to hate crimes. Crimes in which the perpetrator targeted an individual or group due to their sexual orientation or gender identity in 2009 are classified as hate crimes, punishable by harsher and stricter consequences (*Hate Crimes Prevention Act 2009*). This federal recognition allows the government the power to record information about these crimes, publish statistics, and encourage police, law enforcers, and local governments to identify and record information regarding these forms of hate crimes. In 2014, the United States Federal Bureau of Investigation recorded 5,922 hate crimes of which 21.3% were related to sexual orientation and gender identity (FBI 2014). This is up from the 2009 statistics in which 17% of the 7,624 hate crimes were

motivated by sexual orientation (Marzullo 2009). Although hate crimes themselves are consistently dropping in number, the proportion of hate crimes against LGBT people is increasing (FBI 2014, Marzullo 2009). Hate crimes in the United States are primarily linked to race and ethnicity, although these statistics have also decreased from 51% to 48% in 2014 (FBI 2014, Marzullo 2009).

Though various forms of discrimination are prevalent and lawful throughout the United States, the firm federal stance against LGBT hate crimes allows for increased recognition and identification of these forms of crime, while also allowing individuals to press charges resulting in increased consequences for the attacker. Rates are likely increased due to media attention and the current prevalent discussion of LGBT people. Reporting may have also increased since 2009, allowing for a more accurate representation of hate crimes in the United States. These statements, however, are purely speculative. Hate crimes harm not only the victim, but also the community of LGBT individuals in the area. A 2014 study indicated that increased rates of hate crimes in an area caused individuals to be less likely to disclose their sexual orientation or to be satisfied with their life (Bell 2015). These findings also indicated those in communities with higher LGBT hate crimes were likely to make riskier decisions and result in dramatic behavior changes (Bell 2015). Rates of hate crimes in the United States are also linked to higher illicit drug use by LGBT youth (Hatzenbuehler 2014).

The United States scored a 7 in LGBT hate crimes.

Medical Understanding

The medical understanding of LGBT culture in the United States is one of its strengths as it is quite advanced. The American Medical Association (AMA) and the American Psychological Association (APA) each publish their opinions on LGBT related issues in depth. Each has adopted the DSM-5 as the definitive guide for mental and emotional mood disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM) declassified sexual orientation and gender identity as disorders related to mental health. The American Medical Association's non-discrimination policy specifically mentions sexual orientation. The AMA also indicates the recognition of LGBT people as privy to basic human rights, including healthcare (*Policy on LGBT Issues* 2013). The AMA also advises medical schools and residency programs to adopt non-discrimination and human rights policies similar to theirs. They also advise that both programs include education topics relevant to LGBT health and LGBT patients (*Policy on LGBT Issues* 2013). They also believe that health disparities within LGBT communities should be identified and systematically eliminated through providing increased physician education surrounding the topic (*Policy on LGBT Issues* 2013). Provisions for LGBT physicians and healthcare workers are also mentioned. The patient policy is as follows:

H-160.991 Health Care Needs of the Homosexual Population. 1. Our

AMA: (a) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems.

With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their homosexual patients; (iii) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (iv) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (v) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (c) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation.

2. Our AMA will (a) educate physicians regarding: (i) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or

elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk. 3. Our AMA will use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing physician competency on gay, lesbian, bisexual, and transgender health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high quality and culturally competent care to gay men and lesbians (Policy on LGBT Issues 2013).

This exhaustive but incredibly progressive stance indicates that the governing body of American medicine is informed and knowledgeable about LGBT healthcare. The policy condemns conversion therapy and illustrates their understanding of the need to continue education and raise awareness within the medical community. The AMA also believes that denying same-sex marriage to LGBT people is medically harmful (*Policy on LGBT Issues 2013*). They also oppose the lifetime ban on blood donations by MSM (*Policy on LGBT Issues 2013*).

The progressive policies take a stance indicative of the understanding that homophobia within the healthcare system is medically harmful to LGBT people. Their policies show an understanding of risk mitigation and health disparities.

The APA publicly supports LGBT people and recognizes the need to educate and study the harmful effects of society and homophobia on LGBT people. Their policies, similar to the AMA, are progressive and indicate a thorough understanding of homophobia, as well as LGBT culture (*Sexual Orientation and Gender Identity* 2013). The APA also publishes a variety of statements in regards to various policies and news surrounding LGBT culture. For example, the APA supports same-sex marriage, and believes that there is no difference in life outcomes for children of same-sex couples (*Resolution on Marriage and Children* 2013). They also recognize the presence of diversity of gender and orientation in children and adolescents (*Resolution on Gender* 2013).

Despite the progressive statements of medical governing bodies, LGBT patients are still unlikely to come out to their physicians (Margioles 2009). This has tremendous implications for the healthcare of these patients as LGBT individuals are at risk for not only HIV, but other STIs and various forms of cancer (Margioles 2009). The HIV/AIDS epidemic created systemic homophobia related to the disease even within the healthcare field. Older and more conservative physicians have been found to fear homosexual patients and refuse treatment (Hayward 1993). A 1994 study highlighted these discrepancies and found high degrees of homophobia in the doctors they interviewed (Rose 1994). They advised physicians to challenge homophobia in the hopes that HIV could be treated as a medical condition, rather than attaching various stigmatizing factors to it (Rose 1994). Though advances have been made to increase medical education

surrounding the disease, subsets of these physicians likely still practice. These beliefs and actions are not widespread, however, and indicate a progressive state for medical professionals.

For these reasons, the medical understanding of LGBT culture in the United States scored a 9.

Sex Education

Sex education is controlled at the federal and state levels. On the state level, 22 states require sex education in public schools and 33 states require instruction about HIV/AIDS (*State Policies on Sex Education in Schools* 2015). The majority of these states do not mandate what must be covered in sex education. Only 19 states require that sex education must be medically accurate. In many states, this allows a degree of freedom by the school board or the schools themselves to develop sex education curriculum based off of their opinions and experiences. The majority of students, therefore, do not have access to quality, comprehensive sex education.

On a federal level, the U.S. Department of Health and Human Services currently budgets \$114.5 million to support what is termed evidence-based sex education. Evidence-based sex education is defined by a variety of reports that medically accurate information promoting safer sex among teenagers was better linked to positive sexual behavior (Kirby 2008, *Sex Education in the United States* 2012). Research that operationalized sex education and sexual behavior into 17 factors found that more comprehensive programs were more effective in decreasing rates of STIs or unplanned pregnancies.

Reports in the United States have indicated that abstinence-only programs have failed in limiting STI infections and unplanned pregnancies. Despite the prevalence of abstinence education programs, 47% of high school students admit to being sexually active (CDC 2011).

STIs in the United States also disproportionately affect adolescents and young people as those aged 15-24 represent 25% of all STI incidence in the United States (*Policies on Sex Education in Schools* 2015). Likewise, abstinence-only programs are not effective in delaying or reducing the frequency of teen sex, nor has it reduced the number of sexual partners or decreased risk in the teen population (Kirby 2007). Various studies have also found a high degree of factual inaccuracy in abstinence-only based education (Waxman 2004, Trenholm 2007, Kirby 2008). These studies specifically cited that abstinence-only education was positively correlated to HIV infection rates.

The federal government has made strong strides to move sex-education in the right direction. By financing programs that show evidenced-based education, the federal government shows an understanding that more comprehensive sex education is imperative in public schools and that abstinence-only education programs are deficient in accurate information and do not provide appropriate information for risk reduction. LGBT specific information is uncommon and widely only referenced in discussions regarding HIV and AIDS. Despite these efforts, the majority of states still do not require sex-education and abstinence-only programs are prevalent within the United States. For these reasons, the United States scored a 6 in sex education.

Religion

Though the United States Constitution mandates a formal separation of church and state, religious justification is prevalent in US politics. Religious adherence and religiosity are also high in the country. Nearly 75% of the population identifies as some denomination of Christian and 20% identify as atheist or spiritual without religion. About half of those who identified with a Christian religion indicated they attend church every week or more (Pew Forums 2011, Gallup

2012). There is, however, a wide gap between states; while more than 60% of individuals in Mississippi identified as very religious, only 20% in Vermont chose the same answer (Gallup 2014). Regardless of the degree of religiosity, 60% of Americans believe religion plays an important role in decisions (Pew Forum 2002). The majority of Americans would not vote for an atheist presidential candidate, a trend that has increased in the past 20 years (Jones 2007). This degree of adherence is uncommon in developed nations.

Religion is pervasive in politics, despite a clear definition of the separation of church and state. Every president has identified with a Christian religion with varying degrees of adherence. Candidates for Congress and local governments often identify with a religion, most often Christian, and use religious means to justify platforms and decisions in office. Arguments surrounding abortion, sex education, and LGBT culture have a large degree of religious justification (McCann 2011). The degree of homophobic legislation in the majority of states is largely a product of religious convictions about the traditional family and the sinful nature of homosexuality.

The United States is also host to a variety of highly conservative churches and organizations with strong opposition against homosexuality including the Southern Baptist and Evangelical Baptist Churches and Jehovah's Witnesses. The country is also home to the radically conservative Westboro Baptist Church although it is widely condemned.

Religion is prevalent within the United States and its government, thus it scored a 5.

Visibility

Visibility of LGBT culture in the United States is incredibly high. From a wide collection of LGBT characters in the media, to several openly LGBT prominent figures, the United States is host to an incredibly visible LGBT population. The Gay and Lesbian Alliance Against Defamation is an organization dedicated to increasing the visibility of LGBT culture in the media. They encourage networks to increase the number of LGBT characters and highlight the importance of LGBT prominent figures to come out. The majority of television networks now feature LGBT characters (*Network Responsibility Index* 2014). Approximately 4% of all scripted characters on network television are LGBT which is similar to the reported 3.8% of American adults who identify as LGBT (*Where We Are on TV* 2014, Gates 2011). Internet streaming services such as Netflix and Hulu also offer diverse characters at even higher rates. LGBT characters are becoming increasingly prominent in films although progress is much slower than in television networks. The majority of production companies have a few movies with LGBT characters although some offered none or only offered characters that were clearly stereotypes (*Studio Responsibility Index* 2014). The trend, however, is increasing numbers of characters.

The United States has a variety of prominent figures from actors and actresses, politicians, athletes, and CEOs. Pride events are held in nearly every major city in the United States and LGBT clubs and hangout spots are prominent. Efforts in the battle for marriage equality have given many prominent figures the opportunity to offer their opinion, and ultimately come out as well. Though progress can still be made, the United States scored a 9 due to the incredibly high degree of LGBT visibility and representation.

Infection Rates

The infection rates in the United States are outlined below. HIV and chlamydia infection rates were obtained from the Center for Disease Control (*Chlamydia Fact Sheet 2013, HIV Incidence in the United States 2013, HIV Prevalence 2013*)

Table 11: HIV and Chlamydia Infection Rates in the United States

	HIV	Chlamydia
Prevalence	.4%	1.5%
Incidence	.0157%	.89%
Trend of Incidence	Stable	Increasing

Figure 8: HIV and Chlamydia Prevalence in the United States

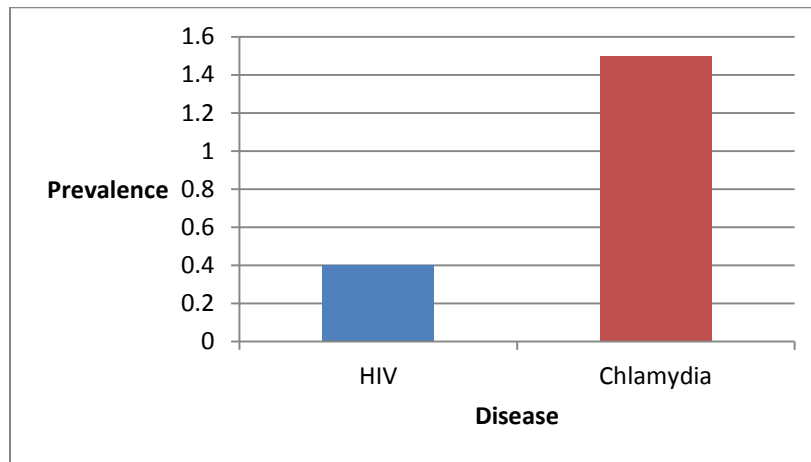
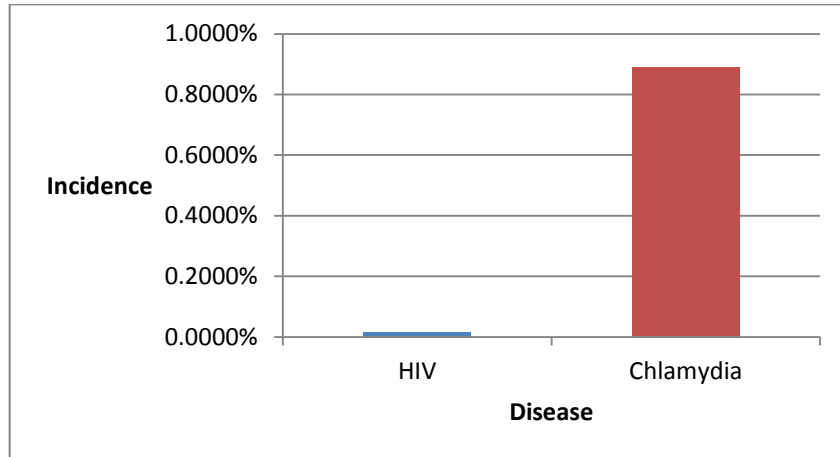


Figure 9: HIV and Chlamydia Incidence in the United States



Conclusion

HIV rates in the United States are higher than those in Spain and nearby Canada. While Canada and Spain systematically eliminated homophobia, efforts to increase equality in the United States have been limited until recently. The recent trends indicate a changing tide and ideally as the federal government overturns homophobic state policies, it will also eliminate systemic homophobia.

JAPAN

Introduction

A changing tide in views and demographics in Japan create an ambiguous dichotomy surrounding LGBT culture in Japan. The elderly, more traditional population comprises the majority of the population. Stigmas surrounding sex and sexuality are prevalent in this population; however, the younger generation is vastly different. Growing acceptance in Japan for sex and sexuality is evident in the discourse among the younger generations. This discrepancy, described in detail below, illustrates the reasons for the very low prevalence of HIV in Japan despite a higher degree of systemic homophobia.

Table 12: Operationalized Homophobia in Japan

Score	1-2	3-4	5-6	7-8	9-10	Score
Level of Marriage Equality	Laws actively criminalize marriage or civil unions	No civil unions or recognition of LGBT relationships	Marriage equality is discussed but openly opposed; civil unions exist	Civil unions exist; marriage equality openly discussed with a possibility of legalization	Partial (only certain states/regions) or full marriage equality	1
Laws Regarding LGBT Population	Homosexuality criminalized by death or prison	Homosexuality illegal- no death; no prison, generally considered lower social status	LGBT Sexual behavior criminalized; “lifestyle” accepted	Rights regarding job security and/or privacy exist	Full rights regarding job security, immigration, security and privacy	6
Rate of Hate Crimes	High degree of violent crimes and/or low conviction	In between; violent crimes still high and conviction higher, or crimes lower but conviction higher	Moderate violent crime and/ or conviction rates moderate	In between; both slightly differ, or one significantly different	Violent crimes minimized, Conviction rates higher	9
Medical Understanding	Homosexuality treated as deviant	Homosexuality as a diagnosis	Not discussed or seen as a “phase”	Homosexuality as a lifestyle choice positive or negative condition; life experiences made you this way	Homosexuality as an orientation, genetic or environmental influences	5
Level of Sexual Education	Sexual education does not exist and discussion of sex is taboo	Discussion of sex occurs in the house or not at all; institutionalized education either does not exist or is rarely used	Abstinence based education; discussion of sex normal among friends	Sexual education in schools exists and includes contraception or STI prevention	Sexual education in schools includes contraception and safe sex on a variety of sexual topics	3
Religious Influence on Policy	Religion controls government; religion dictates homosexuality as immoral	Religion pervasive in the nation and plays a role in government decisions particularly with sex	Religion plays a role in the government but separation of church and state exists	Religion is present in the country but does not directly play a role in legal decisions	True separation of church and state. Opinions of the church are separate from legislation	9
Visibility	No queer representation or very limited	Limited representation and LGBT figures, real or fictional are opposed	Caricatured/ mocked; numbers may be higher or more accepted	Limited representation in media and high earning, visible jobs	High visibility of LGBT in media and visible jobs	5

Total

38/70

Level of Marriage Equality

Currently, Japan offers no provisions for same-sex couples to officially register. There are no available marriage licenses nor can same-sex couples register in civil unions. The Japanese constitution specifically notes that “Marriage shall be based only on the mutual consent of both sexes and it shall be maintained through mutual cooperation with the equal rights of husband and wife as a basis” (Article 24). Though no legislation is currently in the works, 51% of the population believes that some form of legal recognition of same-sex couples should exist (*Same-Sex Marriage* 2013, p. 4). The current legislation provides no recognition and no benefits to same-sex couples, indicative of a score of 1.

LGBT Laws

LGBT laws in Japan are meager for an advanced society such as Japan.

Adoption and Child Rearing

The laws in Japan limit LGBT couples from starting a family. Adoption policies in Japan prohibit single parent adoption and joint adoption by a same-sex couple, limiting access to adoption to heterosexual couples. There are no provisions for commercial surrogacy and lesbians do not have access to in vitro fertilization or other ARTs.

Anti-Discrimination Policies

The government has not adopted a universal policy on discrimination against LGBT people. Therefore, it is legal in the majority of the country to fire LGBT individuals on the basis of their sexuality. Employers may use sexual orientation as the basis for hiring, or in the decision to give promotions or raises. Vendors and companies may deny services or products to individuals on the basis of their sexuality. There are no protections extended to LGBT

individuals who experience discrimination from employers or vendors. LGBT individuals may serve openly in the Japanese military and MSM may donate blood after a one-year deferral.

Privacy and Identity

Japan decriminalized same-sex sexual activity in 1880 and established an equal age of consent at the same time. LGBT individuals cannot be convicted for any consensual sexual behavior. Transgendered individuals have had the right to legally change their gender since 2009. These privacy and identity laws are fairly progressive, particularly considering the deficiencies in other categories. Due to the lack of provisions for LGBT individuals despite proper privacy and identity laws, Japan scored a 6.

Hate Crimes

The rate of hate crimes in general is incredibly low in Japan. Aside from Singapore, Japan has the lowest rate of intentional homicide, and one of the lowest crime rates in general. For comparison, the rate of intentional homicide in Japan is .3/100,000 individuals while the United States stands at 4.7/100,000 (*Global Study on Homicide 2012*). The rate of hate crimes in Japan is significantly lower than in other countries in the study and this number decreases every year. There is no documentation of LGBT hate crimes in Japan, thus an inherent limitation is underreporting; however, considering the overall lower rates, it is unlikely that there are significant rates of hate crimes targeting LGBT people in Japan. Unlike Russia, where reporting is also deficient, Japan does not have external reports of hate crimes which similarly indicates a lack of targeted crime. Japan received a score of 9 in hate crimes due to the lack of hate crimes in general, specifically targeting LGBT hate crimes.

Medical Understanding

The medical understanding of LGBT culture is very complex in Japan. Though homosexuality has been recognized throughout Japanese history, current attitudes surrounding homosexuality vary widely (McLelland 2011). Popular opinions vary, however, the Japanese society appears to emphasize social and psychological etiologies for homosexuality (Furnham 2009). Though many believed it to be of social or psychological etiology, and thus, pathological in nature, most did not believe it was something that could be changed. The majority of these individuals also indicated a high degree of stigma surrounding homosexuality (Furnham 2009). Medical literature surrounding homosexuality is limited. The Japan Medical Association publishes no literature or opinion on LGBT culture. Their website contains no references to sex, sexual orientation, or gender identity (*Principle of Medical Ethics*). The Japan Psychological Association also publishes no official opinion (*Ethical Principles of Psychologists*). Though there appears to be no official medical opinion, homosexuality is not medically treated in Japan. Japan does not classify it as a mental illness, although it appears many citizens and likely physicians hold the opinion that it is a learned behavior (McLelland 2011).

Sex Education

Various health experts both within Japan and outside Japan have identified the lack of sex education and the taboo nature of sex in Japan as a key culprit in rising rates of STIs and HIV (Ishiwate 2011, Tashiro 2011, McLelland 2011). The rapidly rising rates of STI's in Japan has caused concern, generating national and international interest in ways to limit their spread (Tashiro 2011). Unfortunately, sex education programs are met with high resistance in Japan. The majority of teachers see sex education as taboo and do not believe it is their job or authority to teach children and adolescents about the topic (Tashiro 2011). Various NGOs have attempted

to raise awareness about rising HIV infection rates, but the attitude in Japan is largely ignorant of this trend (McLelland 2011, *Japan's AIDS Timebomb* 2004). A variety of NGO's have documented resistance to their missions; however, NGOs targeted to gay populations have seen an increase in testing and are thriving compared to programs with other emphases (Ichikawa 2010). Organizations emphasizing HIV/AIDS awareness including the JapaNetwork, Aichi AIDS Information, and the Chikusa Hokenjo offer HIV testing but funds are limited, testing is low, and the information available is not spread in an effective manner.

The deficiency of sex education in public schools and the resistance of the Japanese people to efforts to improve this deficit are indicative of a score of 3.

Religiosity

Religion is not a primary focus in Japan. Though Japanese culture is largely traditional and conservative in nature, religion does not appear to play a major role in this factor. The predominant form of religion in Japan is the Shinto religion. Shinto makes no explicit condemnation of homosexuality. Historical references to male-male love are prominent and some Shinto gods were seen to be protectors of this relationship. The religion also does not emphasize abstinence. While 42% of Japanese people identify as non-religious or atheist, research has shown this to be an inconsistent difference in cultural understandings of religion (*Religion in Japan* 2006). The Japanese largely practice Shintoism but view this more as a spirituality or reflection. The government ensures a freedom of religion and the Shinto religion plays no formal or informal role in the government or decision-making policies. For these reasons, Japan scored a 9 in religiosity.

Visibility

The visibility of LGBT culture in Japan is complex and seemingly inconsistent. Japanese culture does not generally allow for discussions surrounding relationships or sex, thus, in some ways, the invisibility of LGBT culture in Japan is not entirely unexpected. However, LGBT people in Japan often do not come out and in some cases, end up marrying the opposite sex (Floyd 2001). Conversely, the volume of media representations of LGBT culture is large. On television and in movies, the depictions of LGBT people are largely caricatures used for comedic effect. Cross-dressers and transgendered individuals are not rare in Japanese media; however, their depiction is largely stereotypical or caricatured (*Television Perpetuates Outmoded Gender Stereotypes* 2009). The prominence of LGBT depictions in manga and anime are indicative of a changing tide.

Manga and anime, cartoons pertinent to Japanese culture offer a variety of LGBT characters that are not always caricatured (Onada 2009, McWilliams 2008, Lunning 2007). A subgenre within manga and anime called yaoi focuses on male same-sex relationships. The prominence of these characters is contradictory to societal expectations as Japanese culture limits the ability to discuss LGBT culture. Discussion of relationships or sex in general is limited, thus even more so in the situations pertinent to LGBT individuals. The rising number of LGBT characters is indicative of a changing tide. While far from proportional, the numbers are increasing and LGBT culture is finding its place in Japanese society. For these reasons, Japan earned a score of 5 in LGBT visibility.

Infection Rates

Infection rates are listed in the table below. HIV statistics are estimates from the World Health Organization and the National Institutes of Health. Japan has one of the lowest infection rates in the world; however, it is significant to note that the incidence rate is increasing and Japan sees a rising number of cases in HIV each year (*Infectious Agents Surveillance Report, Rising Tide of HIV 2011*). Chlamydia rates are not available for Japan.

Table 13: HIV and Chlamydia Infection Rates in Japan

	HIV	Chlamydia
Prevalence	.01% (12,730)	*****
Incidence	.000835% (800)	*****
Trend of Incidence	Increasing	*****

Conclusion

The incidence of HIV in Japan is increasing significantly every year. Growing concern for this significant increase has spurred controversy in the country surrounding HIV. As discussed in the analysis, Japan's increasing rate of incidence despite an incredibly low prevalence reveals significant sociocultural conclusions in Japan. Japan may have resisted the original epidemic of HIV throughout the 80s and 90s due to cultural taboos surrounding sex and sexuality. With growing acceptance of sexuality in the country, younger generations are beholden to the expectations of the older generations. A lack of sexual education despite growing acceptance of sex in the country may be driving the skyrocketing rates of STIs in the country.

RESULTS

Overall Results

Figure 10: Systemic Homophobia by Country

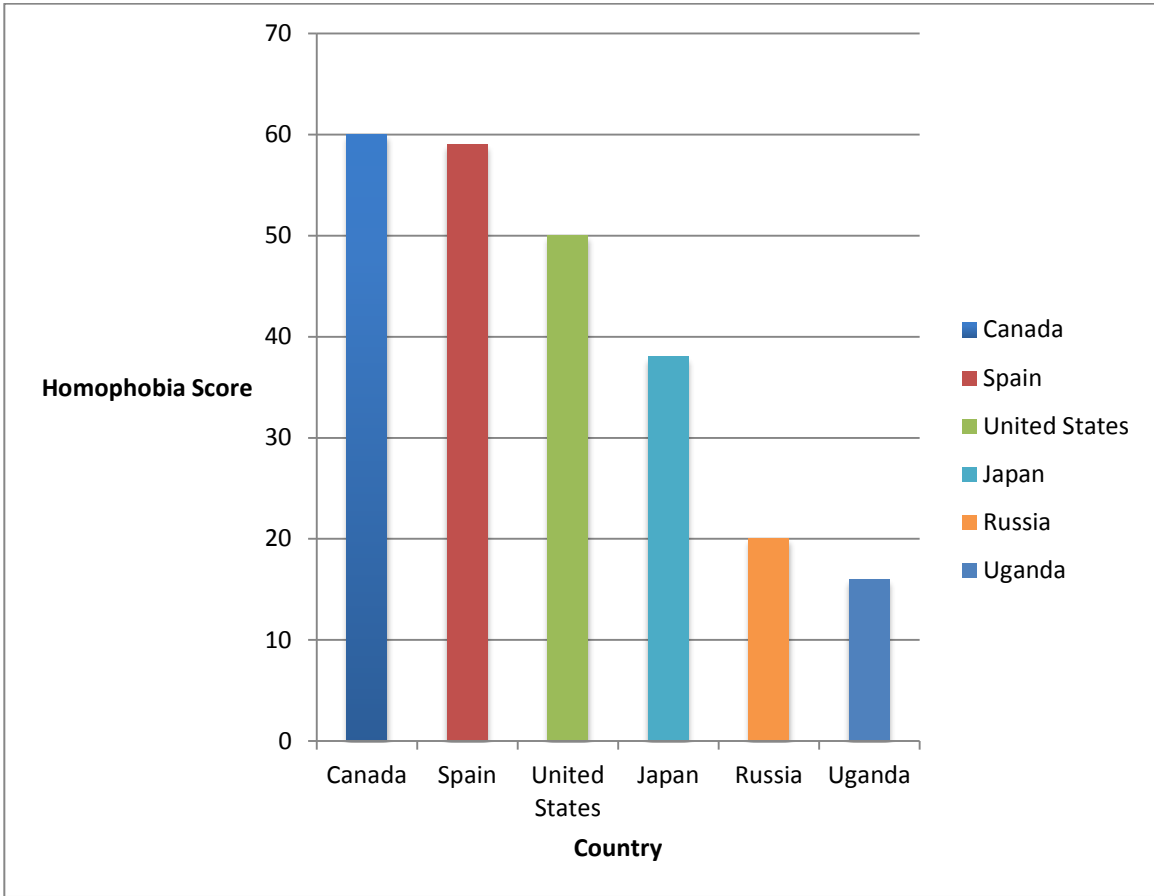


Figure 11: Operationalized Homophobia and HIV Prevalence

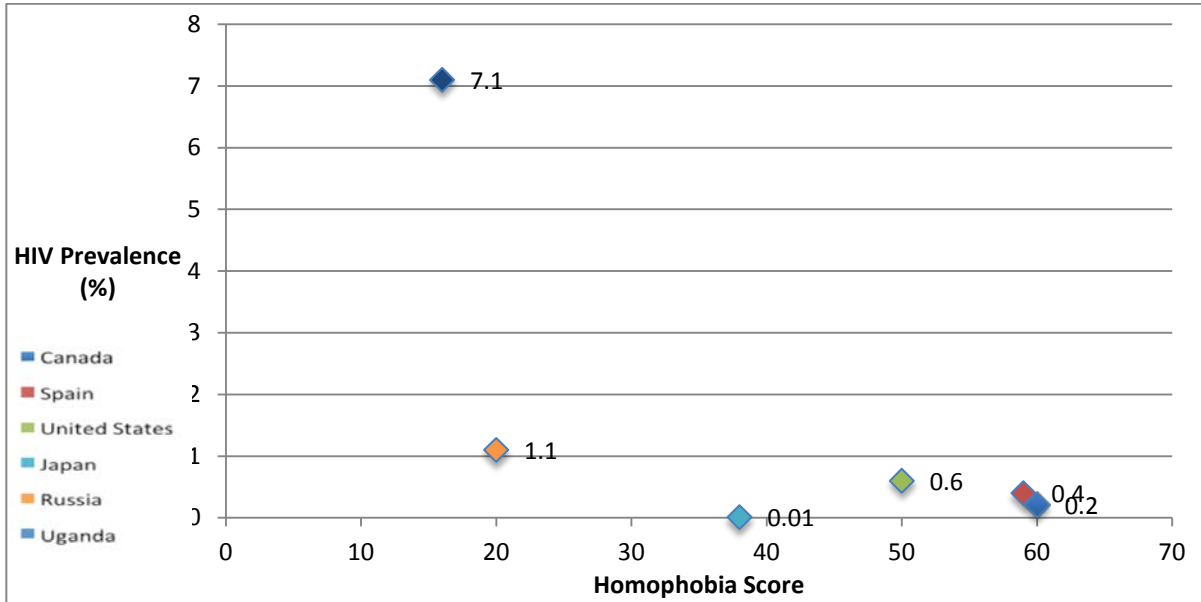


Figure 12: Operationalized Homophobia and HIV Prevalence without Japan, Uganda

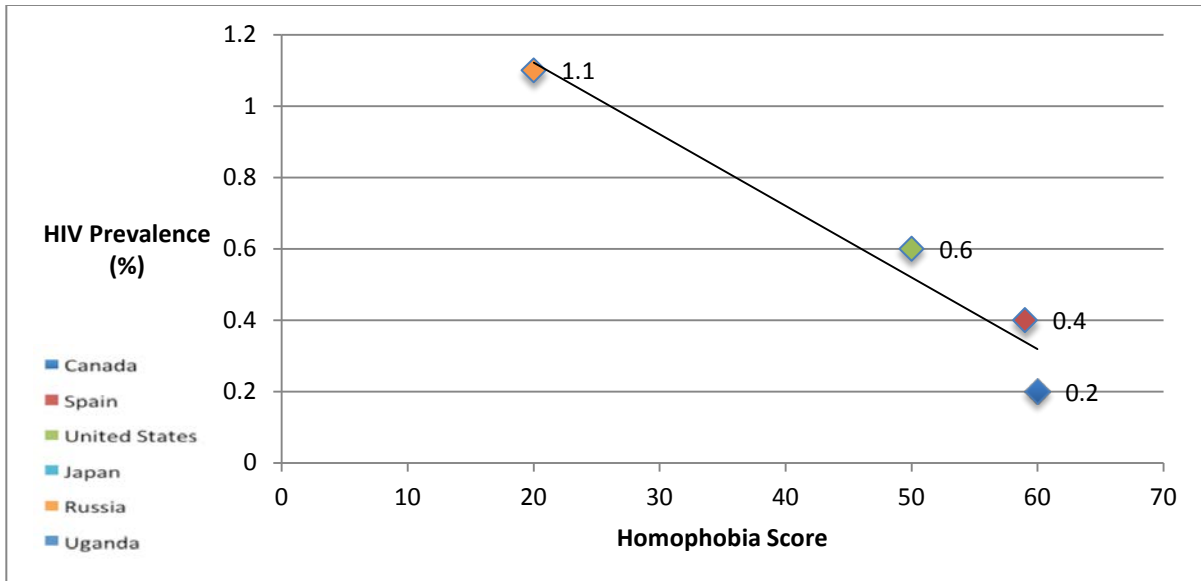


Figure 13: Operationalized Homophobia and HIV Incidence

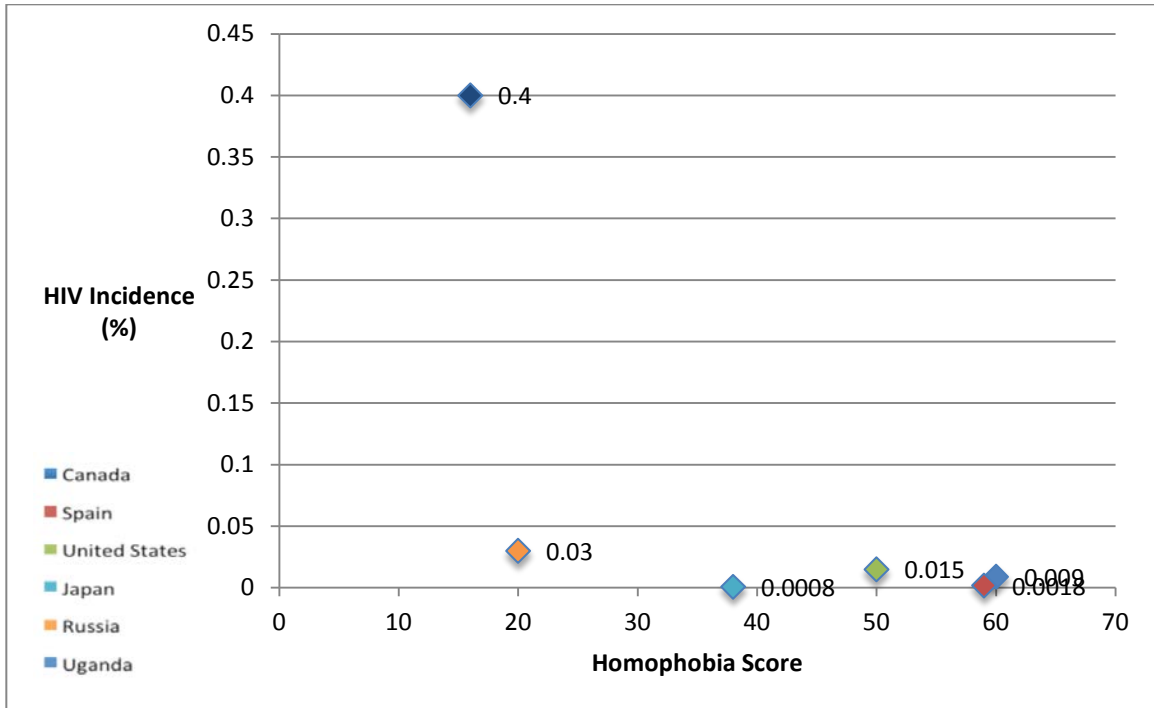


Figure 14: Operationalized Homophobia and HIV Incidence

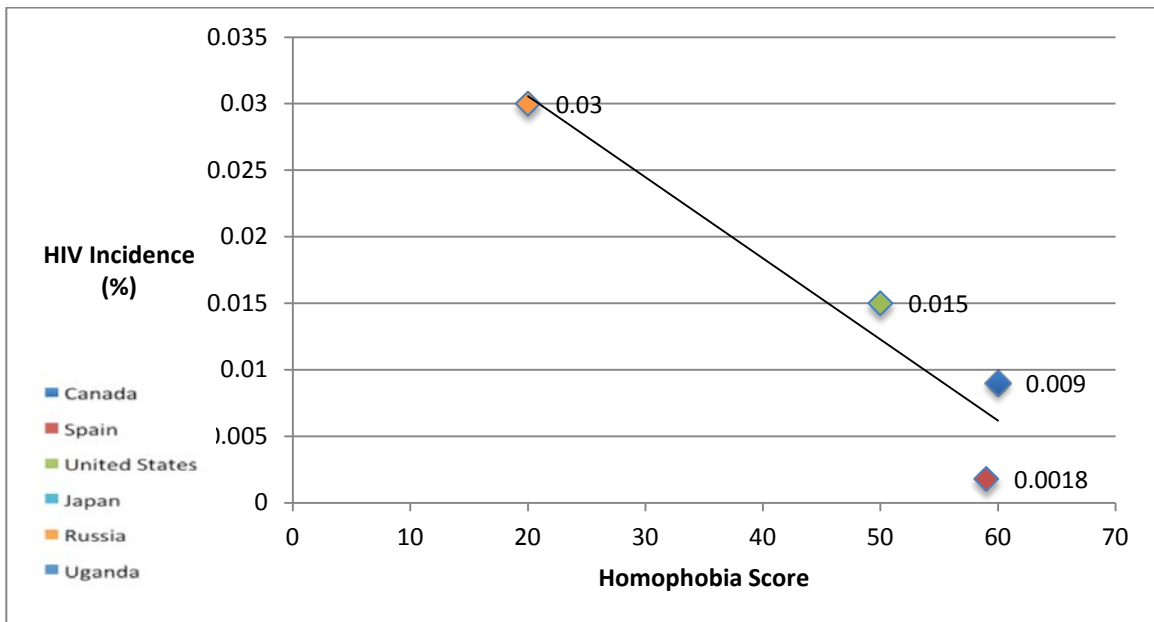
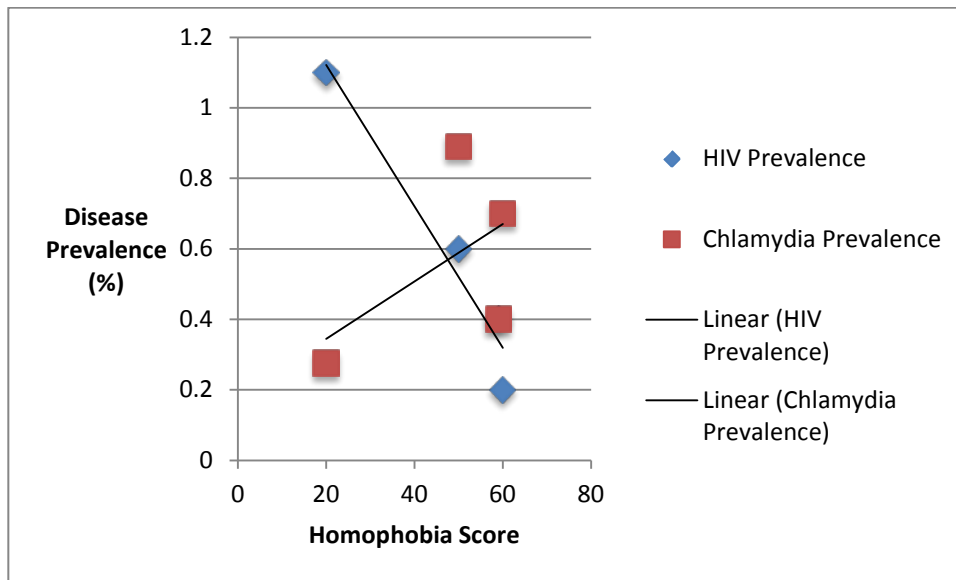


Table 14: Trend in Incidence

Country	Canada	Spain	United States	Japan	Russia	Uganda
Homophobia	60	59	50	38	20	16
Incidence Trend	Decreasing	Decreasing	Stable	Increasing	Increasing	Increasing

Figure 15: Operationalized Homophobia and HIV and Chlamydia Prevalence



Level of Marriage Equality

Figure 16: Marriage Equality and HIV Prevalence

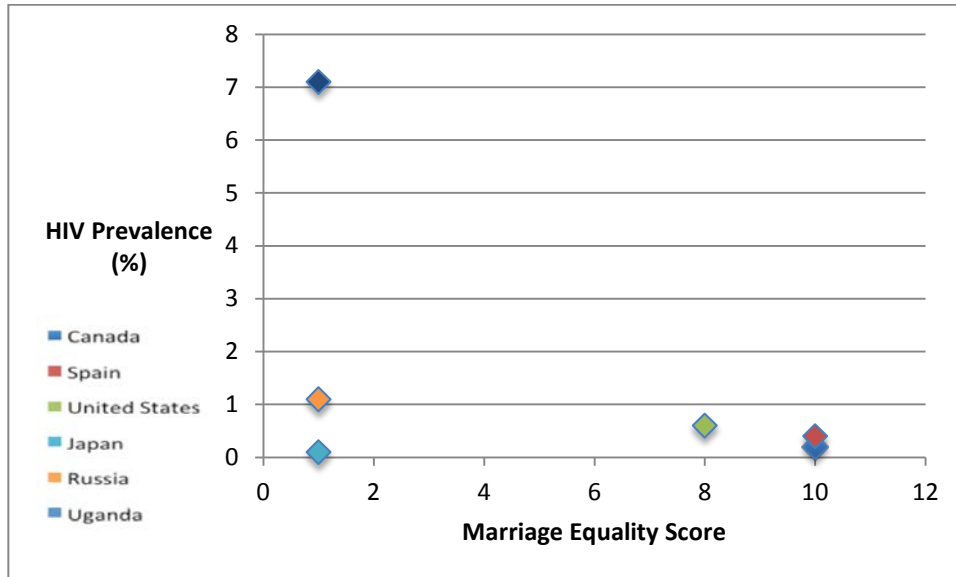
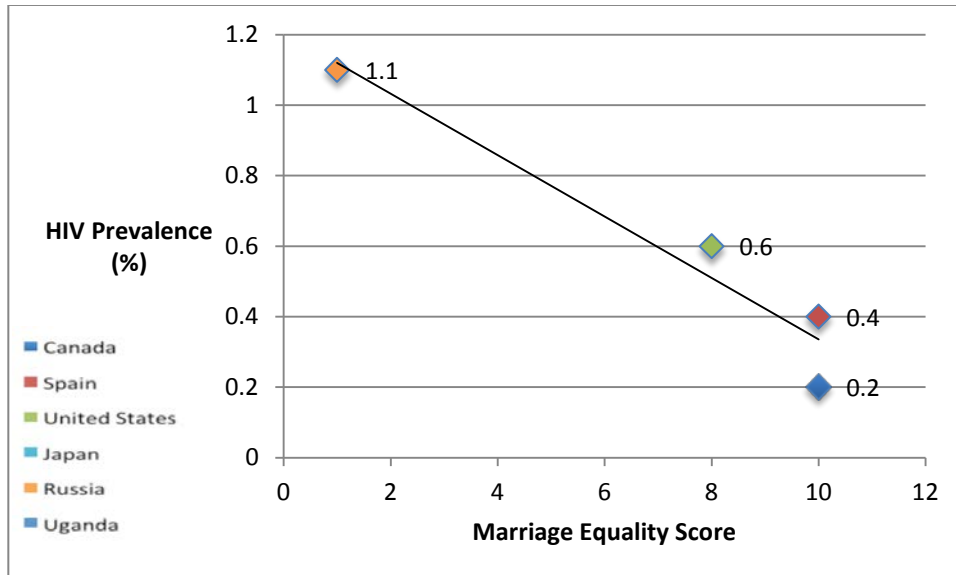


Figure 17: Marriage Equality and HIV Prevalence without Japan, Uganda



LGBT Laws

Figure 18: LGBT Laws and HIV Prevalence

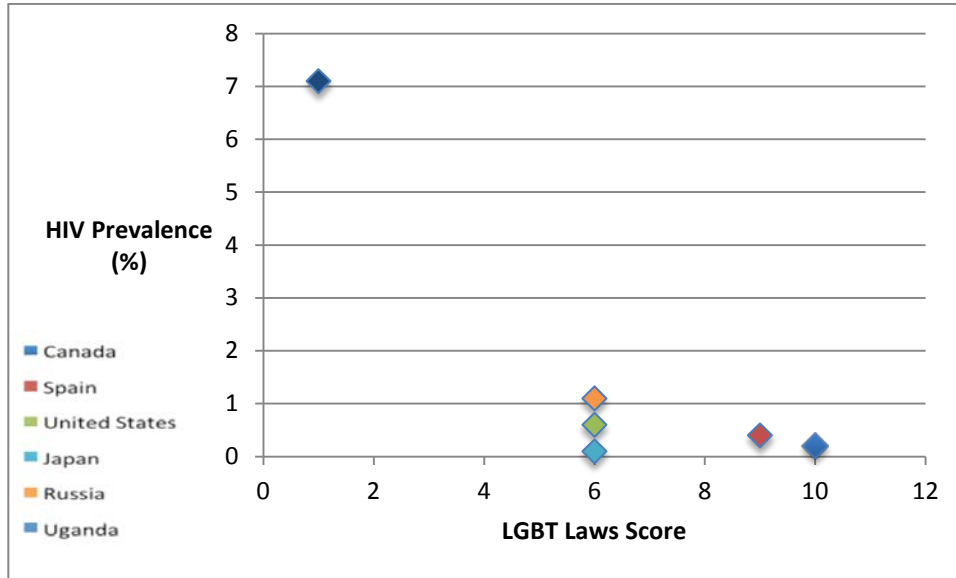
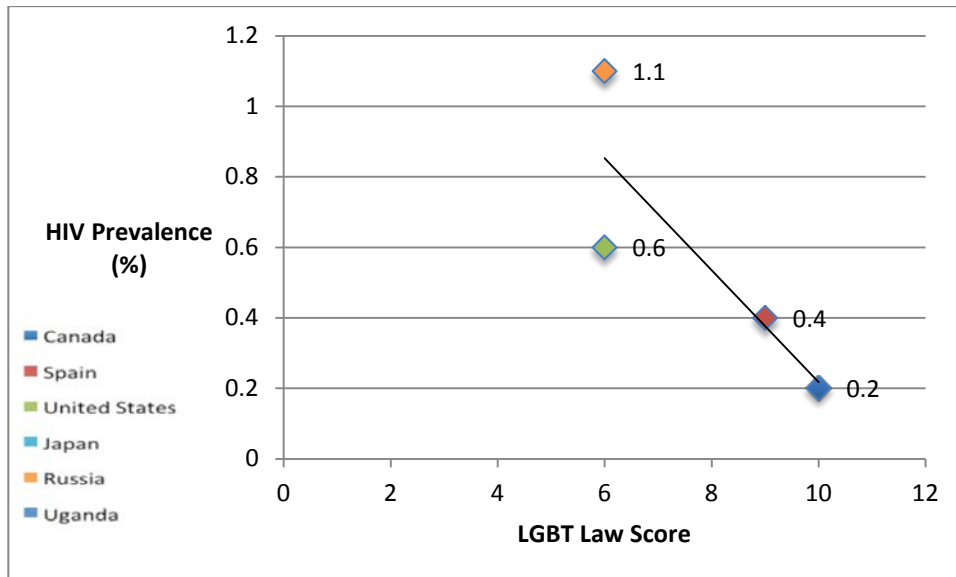


Figure 19: LGBT Laws and HIV Prevalence without Japan, Uganda



Hate Crimes

Figure 20: Hate Crimes and HIV Prevalence

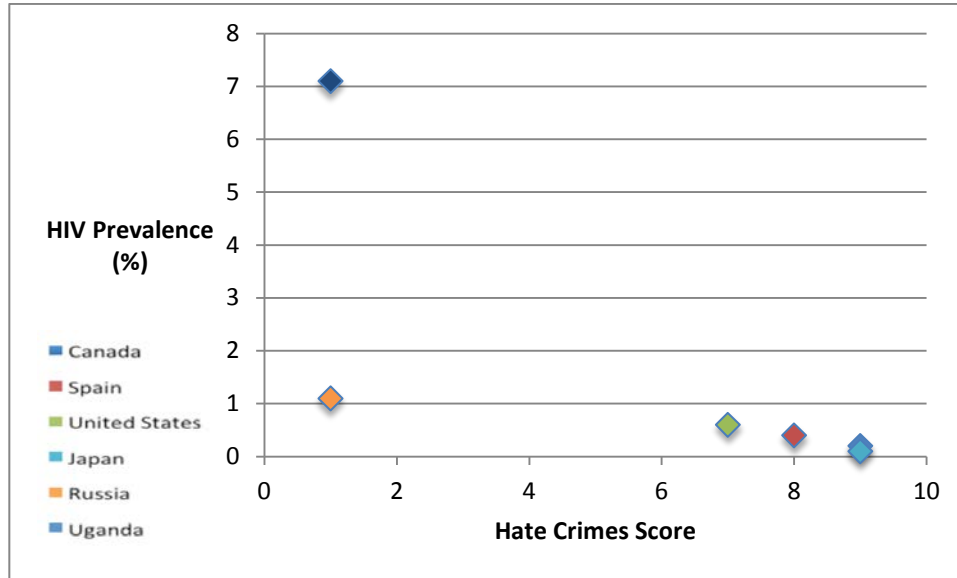
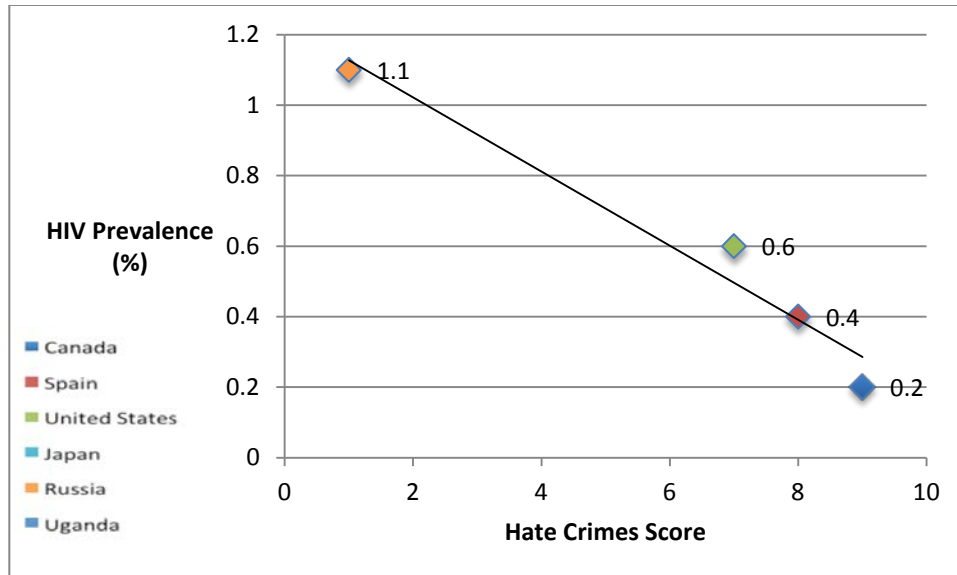


Figure 21: Hate Crimes and HIV Prevalence without Japan, Uganda



Medical Understanding

Figure 22: Medical Understanding and HIV Prevalence

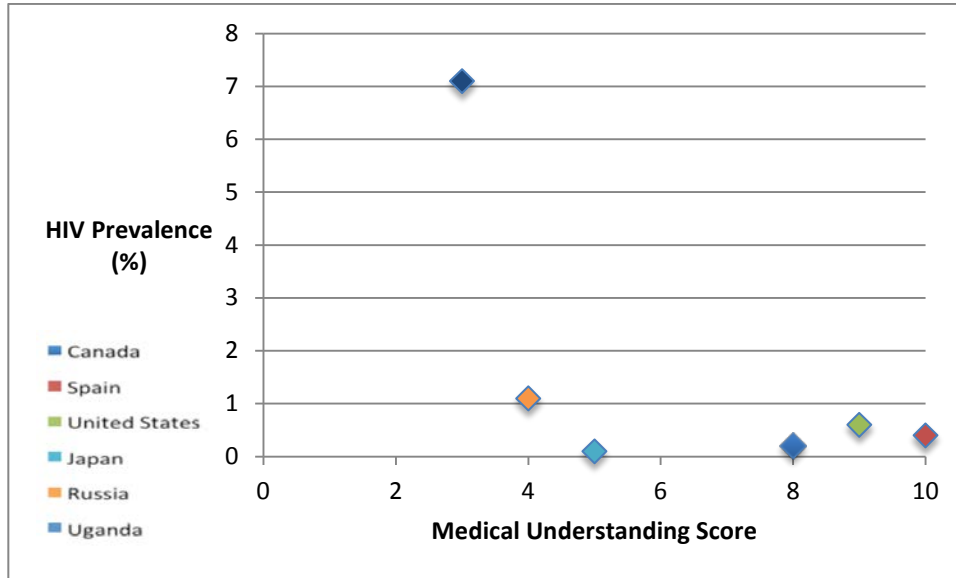
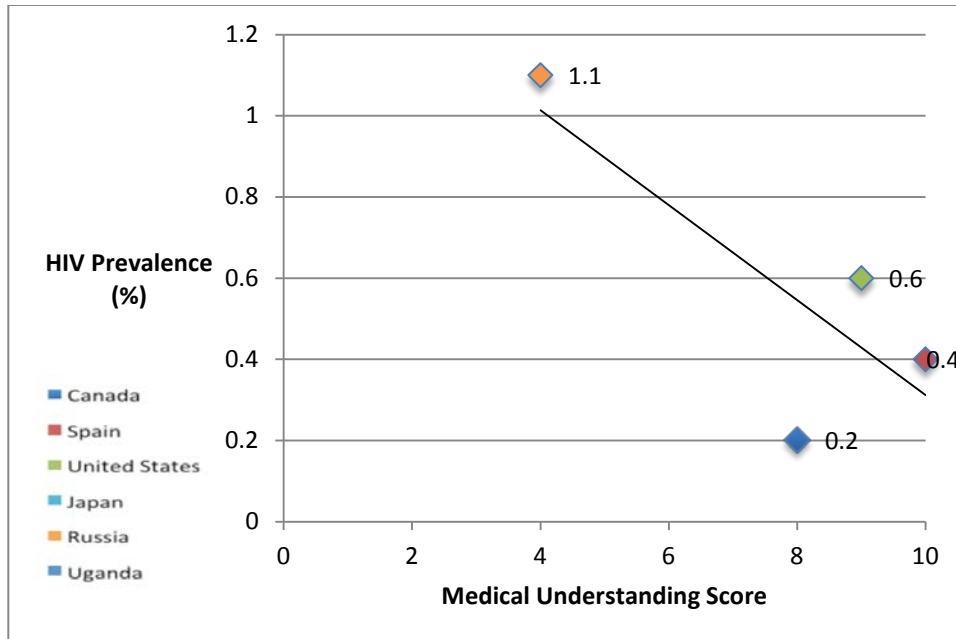


Figure 23: Medical Understanding and HIV Prevalence without Japan, Uganda



Religiosity

Figure 24: Religiosity and HIV Prevalence

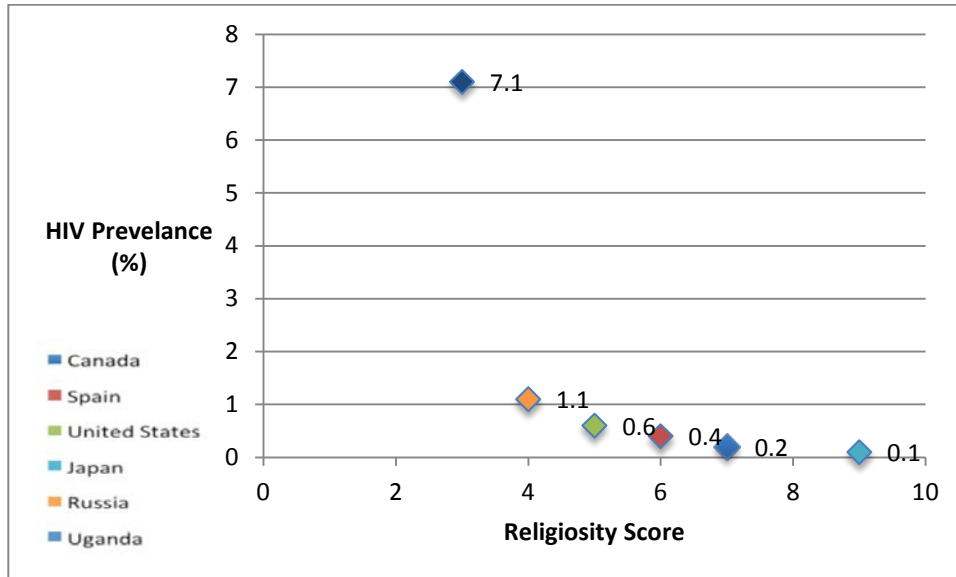
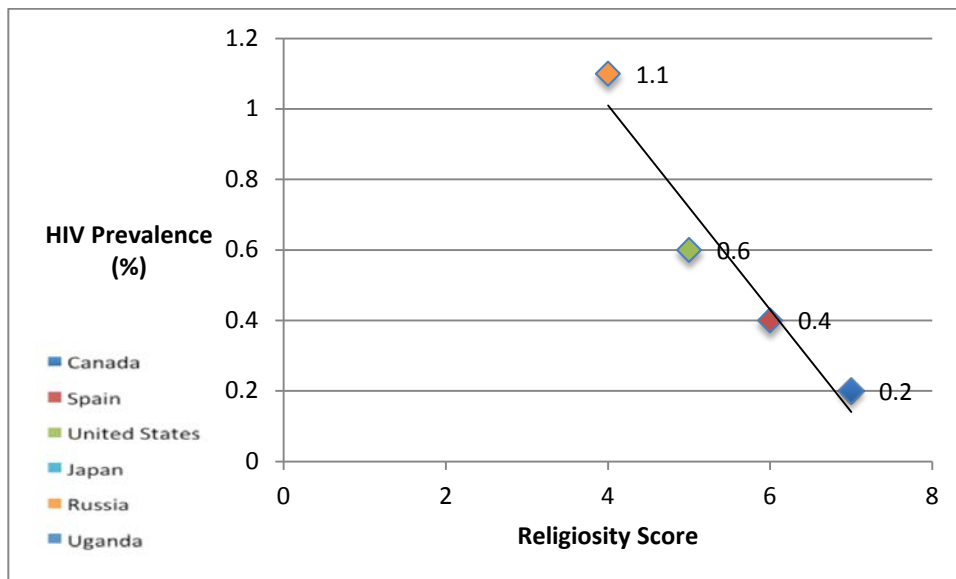


Figure 25: Religiosity and HIV Prevalence without Japan, Uganda



Sex Education

Figure 26: Sex Education and HIV Prevalence

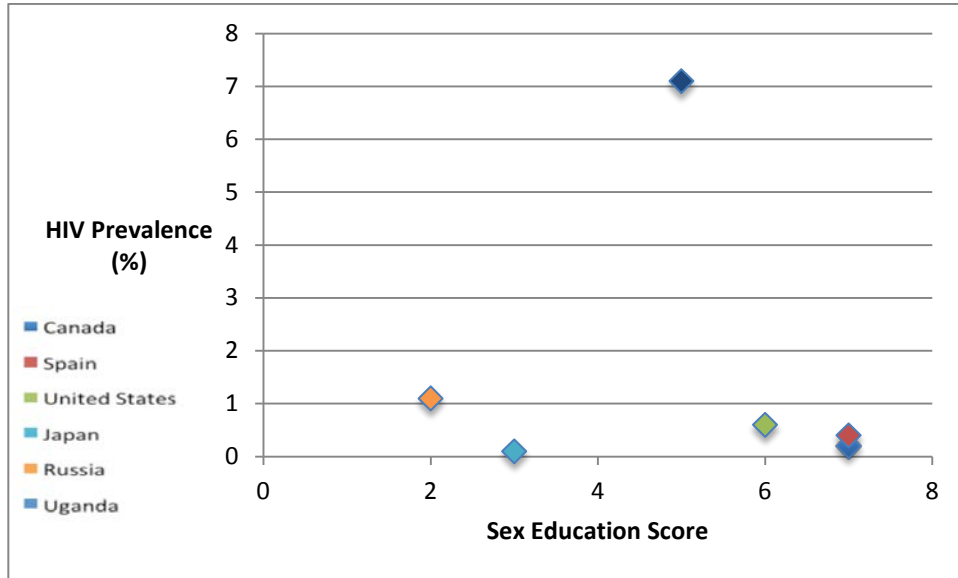
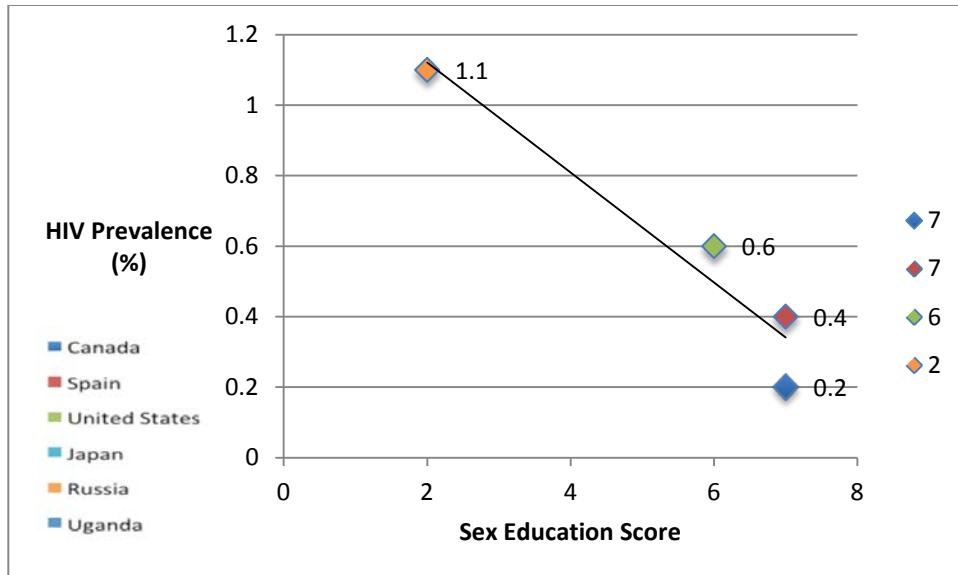


Figure 27: Sex Education and HIV Prevalence without Japan, Uganda



Visibility

Figure 28: LGBT Visibility and HIV Prevalence

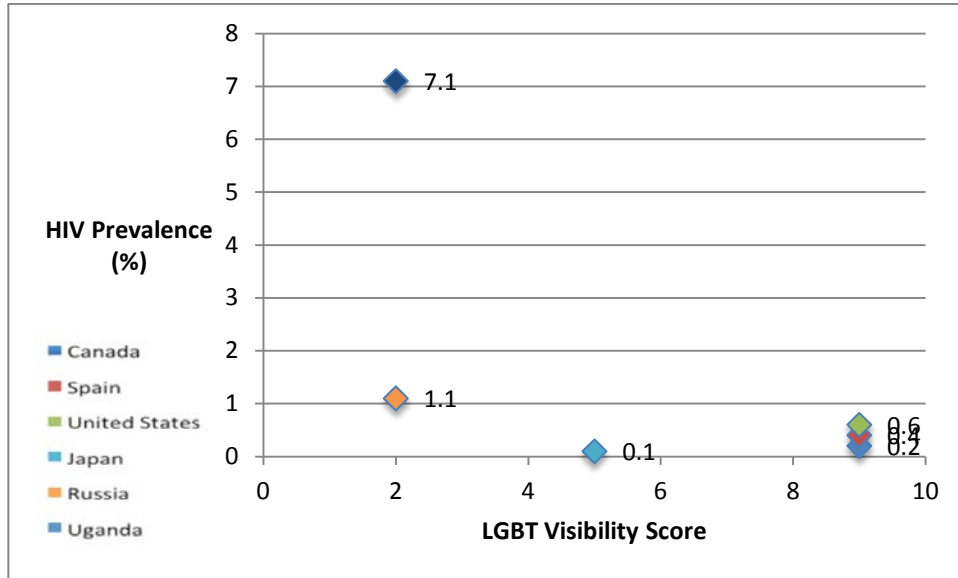
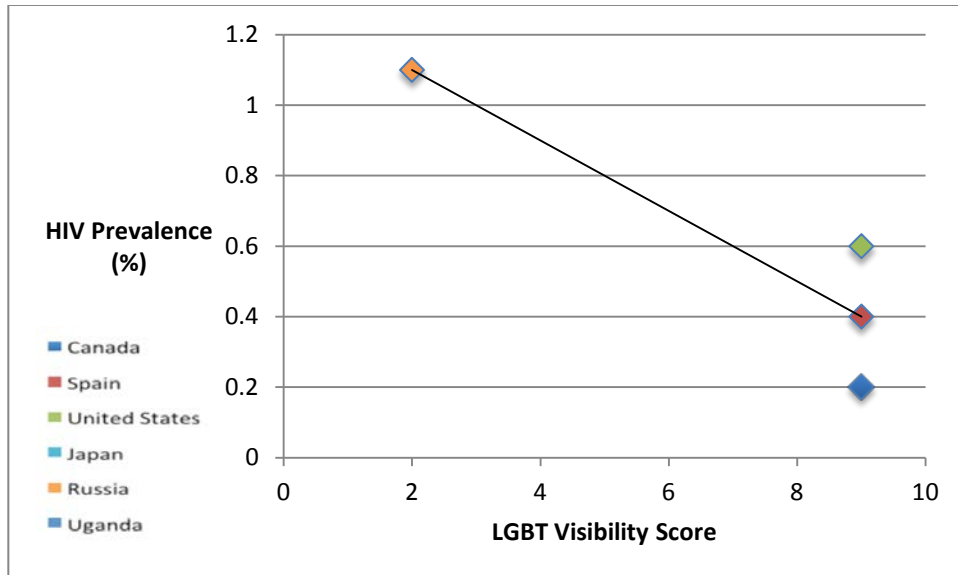


Figure 29: LGBT Visibility and HIV Prevalence without Japan, Uganda



DISCUSSION

The data indicates a positive relationship between HIV transmission and operationalized homophobia. The lower total scores, indicating a higher degree of systemic homophobia, correlated to a higher degree of HIV transmission in all countries except Japan. This trend is visible in both HIV prevalence and incidence. The incidence in Spain is lower than the incidence in Canada despite Canada's one point higher score; however, the trend is still present as the higher rates of transmission relate to the lower scores. The trend in incidence, which indicates whether the incidence is speeding up or slowing down is particularly telling, even in Japan. The two highest scoring countries have decreasing incidence while the United States has about the same number of new cases each year. The lower scoring countries, Japan, Uganda, and Russia, all have increasing numbers of cases each year. As discussed in the Japan section, the numerous reasons for the inconsistencies in this trend and the total cases are related to various sociocultural and demographic factors. Regardless, it is important to note that HIV is in fact on the rise in the countries with lower scores.

The chart titled "*Homophobia and HIV and Chlamydia Incidence*" illustrates that this trend may be specific to HIV. The same trend is not seen with chlamydia prevalence indicating that homophobia impacts HIV transmission over other forms of STI's.

Each section of the results illustrates the relationship for all six countries, with another graph below it that removes Japan and Uganda. Due to the small sample size of countries, it is important to keep all of the data; however, the second graphs indicate this relationship may be stronger with more countries. Uganda follows the pattern, however, with an HIV prevalence nearly seven times higher than that of Russia, it may be considered an outlier. Consideration of

the relationship in the four remaining countries indicates a strong relationship between systemic homophobia and HIV prevalence and incidence.

Each of the seven factors is also compared to the HIV prevalence in order to investigate which of these factors, if any, plays a stronger role in HIV transmission. In terms of marriage equality, all countries except Japan followed the trend. Spain and Canada scored a 10 and each have an HIV prevalence of .4% and .2% respectively. The United States scored an 8 and has a prevalence .6% which is slightly higher than the higher scoring countries. Significant shifts in HIV rates are visible for the lower scoring countries. Uganda and Russia both scored a 1 in marriage equality and their HIV rates are significantly higher. The trend is immediately apparent when Japan and Uganda are removed. In terms of LGBT Laws, the trend is less significant. Three countries scored a six, which does not offer much variation to analyze. However, Uganda's status against Spain and Canada does follow the hypothesized trend. More samples would likely illustrate the trend better.

The score in medical understanding appears to vary and does not follow the hypothesized trend as clearly. LGBT hate crimes appear to be particularly telling of the HIV rates. The increasing score in hate crimes correlated to lower rates of HIV in every country, including Japan. The same can be said for the degree of religious influence. Higher scores related to lower HIV prevalence in all six countries. A similar trend can be seen in the LGBT visibility section, although once Japan and Uganda are removed, there is insufficient variation for analysis. Still, the trend appears to hold, even in Japan.

Sex education follows the trend except in Uganda and Japan. Uganda's implementation of abstinence-only education indicated a score of 5, higher than Japan and Russia where sex

education is absent altogether. Thus, HIV rates in Uganda, which are seven times higher than Russia, are multifactorial such that this difference is likely insignificant. Significant to note as well, is that HIV rates as high as those found in Uganda are uncommonly found outside of Africa. The historical reference for HIV spread in Africa may indicate that more telling in this data is that abstinence-only education programs are not working, just as has been found in the United States. The trend of incidence in Uganda also indicates a higher level of new cases each year, which indicates that HIV prevention methods, including abstinence-only education programs, are not working. Further research with more countries would possibly find a positive relationship between sex education and HIV transmission rates.

Japan's low HIV prevalence and increasing incidence rates is cause for investigation and may highlight its inconsistency in this study and the hypothesized relationship between HIV and homophobia. Japan's demographics indicate the majority of the population is above the age of 50. Traditional Japanese culture constructed sex and sexuality as taboo; conversations and discussion about sex have historically been proscribed. Though the polls outlined in the research indicate opposition to marriage equality, the younger generation appears to be significantly more accepting. This trend indicates an inconsistency in Japanese culture. I theorize, therefore, that Japan resisted the HIV epidemic in the 80s and 90s creating a comparatively lower rate of prevalence. The strong cultural taboo related to sex and sexuality in the country, however, leaves the country without any sex education. As this taboo disappears and the younger generation grows more sexually active, the lack of sex education is becoming more significant; thus, the growing rates of HIV incidence are still related to homophobia. The homophobia of the past that is still systemic in Japan is facilitating transmission of HIV albeit in a delayed setting. Though

there are a variety of sociocultural factors at play, I theorize that Japan is an example of the complex nature of sociocultural relationships with disease. With the disappearing taboo of sexuality, the lack of sexual education, and the skyrocketing rates of HIV, it appears the homophobia of the past is increasing transmission today.

The Medical Understanding appears to be the only factor that does not follow the hypothesized trend. This may be due to complications in operationalizing the factor. Though I chose to score the factor primarily based off of how the medical governing bodies view LGBT culture, this may not have a strong relationship with how LGBT people experience homophobia and stigma in a medical setting. Similarly, the role of how medical governing bodies view homosexuality may not play a role in how doctors actually practice. As was the case in Russia, though a medical body may actively oppose the pathology associated with LGBT individuals, doctors may hold on to related homophobic views.

Hate crimes most closely followed the trend in all six countries. This relationship may be directly linked with the concept of structural violence and structural stigma. In countries with higher rates of related hate crimes, LGBT individuals would likely be less open and be placed in risky situations. To privately engage in same-sex sexual activity, individuals may not procure condoms for safer sex. Similarly, access to information surrounding safer sex practices specific to LGBT populations is likely limited, facilitating increased risk of transmission due to lack of knowledge. As discussed regarding African American populations in the Southern United States, the necessity or desire to stay on the “down low” facilitates increased risk situations and decreased knowledge about STI transmission. In this case, it appears hate crimes are

significantly related to structural violence and structural stigma, thereby facilitating increased transmission among MSM, but also to women through MSMW.

The strongest indicators according to this research are hate crimes, religiosity and religious influence, marriage equality, and visibility. These factors illustrate a strong relationship between the assigned score and HIV prevalence. These factors, as well as the overall score, indicate that systemic homophobia in a country relates to HIV transmission.

Limitations and Future Directions

Two limitations are inherent in this study. Firstly, future studies must expand the sample size of countries in order to investigate this relationship further and with greater depth. While the data suggests a relationship between homophobia and HIV transmission rates, more countries could show a stronger relationship with more data to establish external validity. By choosing countries from various regions, the significant differences in HIV transmission rates become less meaningful. Future studies could compare homophobia against different localizations of HIV transmission. For example, investigating systemic homophobia in Africa in each country could eliminate the various socioeconomic and sociocultural variations in this data set. Secondly, despite obvious attempts to objectivize this study through operationalizing homophobia and using a rubric to assign scores based off of available evidence, research could become stronger by having multiple people score the countries to come up with a more objective score for each country.

CONCLUSION

The HIV epidemic is a prime example of the necessity to better understand the complex relationship between disease transmission and society. Though biomedical research has helped in treating the disease and epidemiologists have helped in decreasing its spread, continued HIV transmission is of public and governmental interest. This project illustrates the beneficial conclusions that can be drawn from interdisciplinary research. Specifically, politicians should investigate social and political causes for increased disease transmission in order to eliminate these factors. With further research and analysis of more countries, this project will be useful in analyzing policies that facilitate HIV transmission in order to encourage governments to adopt less homophobic policies if for no other reason than to decrease HIV risk. Continued efforts by anthropologists to expose these forms of structural violence are essential for epidemiologists, public health scholars, and politicians to better limit the spread of disease. Increased collaboration between these disciplines may prove more fruitful in further decreasing disease transmission thereby establishing a safer and healthier global environment.

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