

HIV Risk for Lesbians, Bisexuals & Other Women Who Have Sex With Women

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Introduction

The vulnerability of lesbians and women who have sex with women (WSW) to HIV infection is a complicated public health issue that is perplexing to some and ignored by many. In fact, female-to-female sexual contact is a much less efficient route of HIV transmission when compared to male/male or male/female sexual contact. According to the CDC, there are no confirmed cases of HIV from female-to-female transmission.

With more than 15 years of experience with lesbians and WSW, the Lesbian AIDS Project (LAP) at Gay Men's Health Crisis (GMHC) knows first hand that there are lesbians and WSW living with HIV. We set about to research the risks lesbians and WSW face in this, the third decade of the HIV epidemic.

This research indicates that some lesbians/WSW engage in high risk behaviors that place them at risk for HIV transmission. Some WSW use injection drugs and may share needles and works. Some WSW have sex, or sexual histories, with HIV-positive men and/or injection drug users. Furthermore, our observations in LAP also suggest that WSW of color in New York City experience a number of environmental adversities that drive risk and confound expectations based solely on their sexual orientation.

Lesbians, long ignored in HIV prevention and service programs, need and deserve tailored interventions and better health outcomes. Beyond that, the examination of the HIV and health risks lesbians face is an examination of the intersection of sexual health, sexuality, identity and stigma in public health programming and policy. This examination yields lessons that should be shared.

The review of the literature makes the case that the risk of contracting HIV is directly related to a woman's experiences and behaviors. The objective of this paper is not to argue that lesbians/WSW are at the same risk as their heterosexual counterparts, but to acknowledge that there is significant risk of HIV, other STIs, and other health disparities for lesbians. These risks are exacerbated by racial disparities in health care access, as well as by homophobia, sexism, and stigma.

Furthermore, this paper seeks to clarify confusion regarding lesbians and WSW risk in order to create visibility for this marginalized subpopulation of women. Prevention and policy interventions must reach more deeply into communities of women and take into account the context of their lives.

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For the purposes of this paper, we will define lesbians simply as homosexual women, or women who have sexual desire and relationships with other women. WSW are women who have, or have had, sex with women who may or may not self-identify as lesbian.

In order to understand the context of risk for lesbians and WSW, we must understand the context of HIV among women. A woman's risk of contracting HIV is directly related to her experiences and behaviors, which cannot solely be determined by the use of labels commonly used to identify an individual's sexuality and sexual identity.

Women & HIV: The context

New surveillance technology developed by the Centers for Disease Control & Prevention, confirmed what many in the HIV and AIDS service fields have suspected for a long time: The HIV epidemic is, and has been, worse than previously known. Results announced in August 2008 indicate that approximately 56,300 new HIV infections occurred in the United States in 2006. This figure is roughly 40% higher than CDC's former estimate of 40,000 infections per year. Women account for more than one quarter of all new HIV/AIDS diagnoses. (CDC, 2008)

Women of color are especially affected by HIV infection and AIDS. In 2004, HIV infection was

- The leading cause of death for black women aged 25–34;
- The third leading cause of death for black women aged 35–44;
- The fourth leading cause of death for black women aged 45–54;
- The fourth leading cause of death for Hispanic women aged 35–44;

In the same year, HIV infection was the fifth leading cause of death among all women ages 35–44 years and the sixth leading cause of death among all women aged 25–34 years. The only diseases causing more deaths of women were cancer and heart disease. (CDC, 2008)

Though the annual estimated rate of HIV diagnoses for black women decreased significantly — from 82.7 per 100,000 in 2001 to 60.2 per 100,000 in 2005 — it remained 20 times the rates for white women. Overall, the rates of HIV diagnosis are much higher for black and Hispanic women than for white, Asian and Pacific Islander, or American Indian and Alaska Native women. The rates for black women are higher than the rates for all men except black men. (CDC, 2008)

Lesbians and bisexual women, like their heterosexual counterparts, engage in at-risk sexual and social behaviors that place them at high risk, including but not limited to: unprotected sex with men, an increased number of sexual partners, the use of injection

drugs, and exposure to fluids known to transmit HIV i.e. menstrual blood, vaginal secretions. Research from 1992 has shown that while a number of women (81%) believe that safe sex is important, only a few (18.7%) actually practiced it when engaged in sexual activity with other women (Russell et al. 1992). More than a decade later, this continues to be a reality for a many lesbians/WSW.

Female-to-female transmission

While lesbians and WSW are at relatively low risk of HIV infection, lesbian sex is not risk free. In 2006, the CDC issued a report stating that there were no confirmed cases of HIV from female-to-female transmission (CDC, 2006). However, the CDC did acknowledge that there have been several documented cases of women who have sex with women that have been infected with HIV. One such individual, a 20-year-old African-American woman, revealed that while she contracted the HIV virus, she did not have a history of the typical signs of risk behavior. She had never engaged in sexual intercourse with a man, did not use injection drugs or other substances, had no tattoos or piercings and had received no blood transfusions. Her only partner was a bisexual female who had HIV. It was concluded that the regular use of sex toys contributed to the contraction (Ghobrial, 2003).

To date, much of the information on female-to-female transmission fails to mention that unprotected oral sex can involve HIV risk if the pleasure provider engages in cunnilingus while the recipient of the pleasure is in the beginning, middle, or end stage of her menstrual period, the woman performing oral sex can be at risk for HIV transmission. In addition, the presence of a large amount of vaginal secretions during oral sex can also pose a risk of female-to-female transmission.

HIV, AIDS and STI prevention education should seek to debunk myths surrounding the female-to-female transmission. Lesbians and other women who have sex with women have been forced to remain in the “closet” of silence and shame about their risks and their HIV status. Much of this has had to do with the ways in which sexual minority groups are overlooked in the epidemic, and the assumption on the part of health care providers that women who have sex with women are at little to no risk for HIV transmission.

Three sexual activities were labeled by the National AIDS Manual (NAM) to be high risk behaviors for HIV. They included oral sex, sharing sex toys and fisting (Farquhar et al., 2001). Actual documented cases of HIV transmission through these activities are

In the book, *Getting Unstuck*, the main character describes, what she believes to have been the way that she, as a woman who exclusively had sex with women, became infected with HIV:

“Oral sex with open fever blisters on my mouth and fingers penetration with open cuts on my fingers and hands. The cuts on my hands caused by the glass dick [the crack pipe] constantly breaking, and the other open wounds on my hands caused by handling cocaine without any protection. What made it worse was sometimes...she bled during finger penetration because nails scratched and pierced the tissue lining along the walls of her vagina during rough sex. It only takes one open cut on a finger to become vulnerable to the virus.”

very few, if any at all. The focus on the use of oral protective barriers has been given too much weight. Some critics note that emphasizing oral protective barriers can be misleading, and that more effort should be focused on other sexual practices that place women at greater risk, such as fisting and sharing sex toys without first disinfecting them (James, 1995).

A study conducted by the Lesbian AIDS Project at Gay Men's Health Crisis in 1992–93 involving 1200 WSW revealed that nearly half of the respondents shared sex toys without the use of protective barriers, and 80% reported that they had never used a barrier when engaging in oral sex (Montcalm and Myer, 2000). Roughly one out of every four women reported oral sex with a menstruating partner in the absence of a protective barrier. More than 25% of the women indicated that they did not possess an adequate level of knowledge about practicing safe sex for self protection (Montcalm and Myer, 2000).

Further, a Kaiser Network published a report that stated 20% of WSW reported sexual play that involved blood exposure and 26% had been diagnosed with an STI (Kaiser, 2001). Approximately one third of the women in the study reported that they had a male sexual partner. 84% of the women believed that they were at “zero risk” for HIV and STI's, despite the fact that most of the women engaged in “multiple episodes of unprotected sex every month that involved potential exchange of vaginal secretions, blood and semen” (Kaiser, 2001).

Little research has been devoted to the study of lesbian/WSW sexual play. Sexual practices that include genital-to-genital rubbing, sex play with toys absent of protective barriers, stimulation of genital/anal areas with hands and mouth, and other sex play that involves fluid exchange needs further study. The relationship between what constitutes sex between women and women's risk of HIV certainly deserves more attention.

A Lesbian Sexual Health and Behavior survey from London found that of the 91% of women who had performed oral sex on another female, only 14% reported using dental dams and only 1% stated that they had always used dental dams (Farquhar, 2001). A study involving Latina women who had high risk behaviors revealed that many women reported having sex with other women, but did not consider themselves lesbians (Dworkin, 2005). One woman reported participating in sadomasochistic sex play, using drugs, not washing sex toys, and having had exposure to blood. Another woman stated she enjoyed performing oral sex on her menstruating partner. Genital-to-genital rubbing was also reported. The CDC supports the fact that HIV can be transmitted through bodily fluids such as vaginal secretions, blood and menstrual blood (CDC, 2006). However, documenting the actual rates of transmission or numbers of cases involving WSW remains difficult with the current standards of classification, which are inherently heterosexual and biased.

How do lesbians contract HIV or AIDS?

While there are no confirmed cases of female-to-female transmission, and virtually no dialogue about lesbian risk, many self-identified lesbians are living with HIV. Many wonder how lesbians contract HIV and AIDS. The literature has indicated that women who have sex with women are at an elevated risk for contracting HIV if they engage in high-risk activities.

This has been supported by research that indicates WSW has been shown to:

- Believe that they are at no risk for contracting HIV (Kaiser Network, 2001),
- Engage in injection-drug use (Young et al., 1992)
- Report higher rates of sex with bisexual men and IDUs (Koh et al., 2005)
- Engage in sexual activity with men (Rosario et al., 1999)
- Are less likely to discuss their sexuality with their physicians (Meckler et al., 2006)
- Are more likely to report low levels of physical and mental health (Marrazzo, 2004)
- Report barriers to accessing healthcare. (Solarz et al., 1999)

Perception of risk

WSW are at an increased risk for HIV when they believe that they are part of a low-risk population due to their sexual identity (Young et al., 1992). This false sense of immunity or protection masks the risks that WSW face.

The Journal of the Gay and Lesbian Medical Association reported 84% of the 503 WSW surveyed said they were at “zero risk” for HIV or other STI exposure, despite the fact that these women engaged in sexual play that included exposure to blood and other bodily fluids and/or included a male partner (Kaiser Network, 2001). Women are not socialized to talk openly and honestly about sex; whether it is with the same or opposite sex. Both in America and globally, lesbians — particularly lesbians of color — deal with enormous cultural standards that try to dictate how they sexually express themselves and explore sexuality. Women from different cultural, geographical backgrounds and religious affiliations experience varying degrees of risk. Stigma and discrimination, community alienation and overt homophobia are typical issues that African-American and Hispanic women, whose cultural backgrounds include Christianity, Judaism, and Islam, face from their communities. Homosexuality is often frowned upon, and in some countries punishable by death. Women of these religious and cultural backgrounds often experience low self-esteem, which directly impacts their ability to negotiate latex barrier use with sexual partners, whether they are male or female.

In communities of color, HIV diagnosis rates are significantly higher for Black and Hispanic women compared to White, Asian/Pacific Islander, American Indian or Alaska Native women (CDC, 2007). Reasons for not using barriers such as condoms differ among ethnic groups as well. One study found that African American women did not use condoms due to low self-esteem and empowerment. Lack of social resources, such as social support, was a predictor for decreased condom and other barrier use for Latina women (Nyamathi et al., 1995). In addition, obtaining health information and services specific and culturally sensitive to lesbians and WSW proves to be more of a challenge for those women living in rural areas, most notably in older generations of women (Butler, 1996).

Sexual identity is not indicative of sexual behavior. There remains no set definition of “lesbian”, which further complicates this area of research. Furthermore, definitions of “lesbian” can differ among cultural, racial and ethnic groups. Some women who identify as “lesbian” may also engage in sexual activity with men. Conversely, some women, such as the Latina women in a Los Angeles survey of high-risk women, would identify with the statement, “Sure, we have sex with women, but we’re not lesbians” (Dworkin, 2005). Countless numbers of women believe that they are at zero-risk for HIV simply because they have sex with women. But what constitutes sex between two women? It has been identified that the HIV virus can be transmitted through blood and menstrual blood, breast milk and vaginal secretions (CDC, 2006). To state that women who have sex with women are at little to no risk of HIV disregards those whose sexual play involve these known methods of transmission.

Injection drug use

Research has shown that WSW who are also injection drug users (IDUs) have a higher rate of HIV infection than non-WSW IDUs. Between 20–40% of injection drug users are women who have sex with women (Dworkin, 2005). A study that included heterosexual men and women, as well as men and women who had same-sex contact, revealed that the highest prevalence of HIV infection was among women who have sex with women (Diaz et al., 2001). While women who have sex with women may not necessarily engage in injection drug use themselves, many do have sexual partners who are injection drug users. Thirty-nine percent of WSW in one study reported that their male sexual partner had sex with other men, and roughly 20% of these women believed that their male sexual partner had a history of injection drug use (Hollander, 1996).

WSW IDUs were also found to have more male sexual partners and more likely to have sex with an individual who was an IDU or HIV positive (Friedman et al., 2003). WSW IDUs reported that they were more likely to have unprotected sex MSM, share needles, exchange sex for drugs and other goods, and have sex with a partner that either was an IDU, or infected with HIV (Ibid).

It also important to note that sharing drugs with another person is an “intimate event.” The likelihood that sex play will occur is heightened by the stimuli of the drug being shared particularly between two or more women. Sensuality and sexual expression among women is very common. Women are more playful with one another and freer in the expression of affection to another. When substance use is involved often latex barriers are not used during such intimate exchanges.

Sex with men

According to the Centers for Disease Control and Protection (CDC), HIV risk behaviors for WSW include: injection drug use, unprotected vaginal sex with men, as well as sex with men who have sex with men (MSM) or men who are injection drug users (CDC, 2006). Many studies have gathered supporting evidence that lesbians and WSW engage in sexual activity with men. Eighty-five percent of WSW reported having sex with men, according a study in American Journal of Public Health (Bailey, 2007). In general, WSW are more likely to engage in sexual activity with a bisexual or gay man (Dworkin, 2005). In LAP's experience, some lesbians who have sex with gay or bisexual men do so, in part, because they feel safer with a man who also has same-sex attractions or behaviors.

Some research indicates that women who have sex with women (WSW) engage in higher rates of higher-risk behaviors, on average, than heterosexual women. Women who reported same-sex contact showed higher rates of infection WSW than women who said they were exclusively heterosexual (Bevier, 1995). Compared to heterosexual women, WSW were more likely to have sex in exchange for money or drugs, inject drugs themselves and use crack cocaine. Of the women who reported same-sex contact, 93% also reported sexual contact with men (Bevier, 1995). A 2007 study revealed that women who reported having sex with both women and men) were as likely to report vaginal intercourse as women who reported sex exclusively with men. WSW were also more likely to participate in anal intercourse, oral sex, or other genital contact not leading to intercourse with men than were women who had sex exclusively with male partners (Mercer et al., 2007).

Equally, many female adolescents who are attracted to or sexually active with other females also report having sex with males. Many lesbian and bisexual young women have sex with males in an effort to convince family members that they are not gay (Rosario et al., 1996). This is also true of many young, gay men. The impact of bisexuality, homosexuality and social stigma on a woman's risk for HIV transmission, remains a challenge in efforts to reduce HIV and STI infections among women, especially young women.

Barriers to health access

There are many barriers to accessing health care that confront lesbians and WSW. Institutional and social barriers are among some of the restrictions that these groups of women face. For those in same-sex relationships, domestic partner health benefits are most often unavailable. These policies vary by state and differ among employers and health insurance companies. Stigma, discrimination, gender norms and gender inequality, heterosexism and homophobia all complicate women's accessing health services as well as their obtaining pertinent health information relevant to the risks and disparities lesbian and bi-women face. In general, compared to heterosexual women, lesbians and WSW are more likely to report being uninsured, having difficulty in finding care, being unable to afford care, and being less likely to obtain preventive health care (Los Angeles Gay & Lesbian Center, 2000).

Another common barrier to comprehensive care for lesbians continues to be lack of training and cultural sensitivity to women who have sex with women. In a 2008, the Lesbian AIDS Project conducted two sexuality focus groups, with eleven self-identified lesbians of color. The majority of respondents reported feeling that health and service care providers lack training and information on lesbian health. Respondents shared experiences of being dismissed whenever a request for HIV testing was made. Testing was often not offered at all because of the assumption that lesbians are not at risk for HIV infection.

There has been minimal attention given to female-to-female transmission by local, state and federal health departments. Because of the current construction of risk, there are no lesbian or WSW-specific HIV prevention interventions sanctioned by the CDC, for example, in the Diffusion of Evidence-Based Intervention (DEBI) program.

The Mautner Project, a leading national lesbian health organization, found that 75% of lesbians delayed obtaining health care, compared to 54% of heterosexuals. Financial concerns were among the leading the causes (Mautner Project, 2005). Seventy-five percent of lesbians reported experiencing discrimination at health care offices; 16% of lesbians reported that it was for this reason that they delayed seeking healthcare. It is also likely that due to the perceived minimal risk of STI and HIV infection, many lesbians and bisexual women do not seek health care, with the belief that they are immune. When asked about health risks that lesbians are concerned about for themselves, the highest ranked categories were being overweight or out of shape and getting older; no one reported HIV/AIDS as a concern (Mautner, 2005).

A recent survey administered by the Woman's Institute of the Gay Men's Health Crisis attempted to identify strengths and weaknesses of a particular outreach initiative, "We're Not Taking It Lying Down!" The survey also sought to understand the way in which women of color engage topics such as stigma, barriers to women getting tested for HIV,

and overall knowledge about the epidemiology of HIV and AIDS. Stigma was the main reason why women did not pursue HIV testing. Fear of what the results may be (64.4% of the respondents chose the top three values for fear) and concern over what others may think (58.7% of the respondents chose the top three values for concern) were among the other main reasons as to why many women avoided testing for HIV. Thirty-five percent of the respondents, (all women of color), reported that they believe women of color are “almost certainly” likely to test positive for HIV; 42% reported that it was probably likely that women of color would be infected with HIV (Pierce et al., 2008).

The Institute of Medicine (IOM) released a report entitled, *Lesbian Health: Current Assessment and Directions for the Future*. The report showed that lesbian women had higher levels of alcohol and substance abuse, compared to women in general. The IOM report noted that while the two main factors for transmission remain sharing needles and having unprotected sex with men, the possibility of female-to-female HIV transmission exists, and deserves further research (IOM, 2000).

A British study published in the *American Journal of Public Health* concluded that women who reported sexual contact with women were at risk for adverse health outcomes compared to women who only had sexual contact with men (Mercer et al., 2007). Women who had a history of same-sex contact were more likely to have more male partners, and report higher levels of unsafe sex, smoking, alcohol consumption, intravenous drug use, and sexually transmitted infection diagnoses (Mercer, et al, 2007).

Lesbians and WSW report lower levels of physical health than their heterosexual counterparts, including lower levels of mental health (Marrazzo, 2004). Furthermore, research has supported the notion that decreased mental health and self esteem can lead to substance abuse and other HIV risk behaviors, especially among impoverished women (Nyamathi, 1995). Due to adversity such as homophobia, LGBT youth have been shown to be at greater risk for substance abuse, depression, attempting suicide, running away from home and dropping out of school (LA Gay & Lesbian Center, 2000). A study that explored substance use among lesbian, gay and bisexual youth showed that female, gay and bi-youth were more likely to engage in substance abuse than males, placing them at a higher risk (Rosario, Hunter, Gwadz, 1997). The coming out process for LGBT youth also has been found to be associated with substance abuse (Rosario, Schrimshaw, Hunter 2004).

LGBT youth have also been found to participate in high risk sexual behaviors, including: an early age for sexual initiation, high numbers of sexual partners, exchanging sex for goods (food, money, shelter, resources), and unprotected sexual activity (Rosario et al., 1999). Female youth in this study also reported engaging in: sex with a risky partner, unprotected oral and vaginal sex, sex when drugs were used and sex during menstruation (Rosario, et al., 1999).

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In study involving 1,304 women that examined the sexual behaviors of women in low risk populations, 11% identified as bisexual and 40% identified as lesbian. Bisexual women reported substance use with sex at a higher rate than lesbians or heterosexual women (Koh et al., 2005).

Environmental & other structural issues

Women who have sex with women face multiple systems of oppression that invariably impact their lives and place them at risk for HIV infection. The most obvious of these oppressive systems, continues to be gender bias and discrimination, which plays out in people's lives, whether it is at work, home, school, and in religious cultures. Patriarchal practices still plague a great majority of the US' social norms and mores, including medicine.

Homophobia and stigma exacerbate HIV risk for women. Due to the psychosocial and environmental barriers that many people of color must face, many individuals may be forced to assert their cultural, religious or ethnic identities over their sexual identity. Many young people of color are less likely to be out with their sexual identity to their parents (Groves et al., 2006). A majority of the women in the United States who are HIV positive are women of color. HIV/AIDS disproportionately affects women of color, and WSW who are also women of color are not immune. HIV infection was the leading cause of death for Black and African American women ages 25–34 in 2005. For Black and African American women between the ages 35–44 years old, HIV infection was the third leading cause of death, and the fourth leading cause of death among Hispanic women of the same age bracket (CDC, 2007). Comprehensive reviews have found that women who have sex with women make up 20% to 40% of female injection drug users across samples (Dworkin, 2005). Certainly, this is another group that faces stigma and oppression from mainstream society. WSW IDU's have also shown to have been more likely to have lived homeless, been institutionalized in a mental health facility, and to have been incarcerated (Friedman et al., 2003)—all aspects that can adversely affect the well-being of these women. Socioeconomic factors also play a role in these women's lives. Approximately 25% of African Americans and 20% of Hispanics live in poverty (CDC, 2007). A 2005 national survey revealed that health costs and inadequate health care coverage were among the top reasons that WSW did not seek health care (Mautner, 2005). Many women forego preventative care health services and are excluded from high quality health care.

All of these factors have the strong possibility of impacting an individual's mental health and self-esteem. As these areas of health decline, an individual is more likely to engage in risky behaviors such as drug use and unprotected sex with partners (Nyamathi et al., 1995). Positive support of one's identity, including sexual identity, is also linked with physical and psychosocial well-being. The coming out process is one area where this is especially necessary, as it has also been found that there is a relationship between HIV risk and non disclosure of one's sexual identity to health care providers (Groves et al., 2006).

Violence

Lesbian, gay, bisexual and transgender (LGBT) youth experience higher levels of violence, stigma, mental stress, suicide and substance abuse, all of which have the potential for increasing one's risk of HIV (Saewyc, 2006). Subsequently, those individuals may not have support systems built into their social networks, meaning they don't have where they feel comfortable, supported, cared for and loved. Coping with homophobia, violence, abuse, stigma and lack of support may lead individuals to engage in activities that put them at an increased risk for HIV.

LGBT adolescents are also been more likely to be the victims of a sexual abuse. Similarly, adolescents who have experienced sexual abuse are at an elevated risk for engaging in unprotected sex, sex with multiple partners, prostitution, and use of drugs, including injection drugs (Saewyc, 2006), thereby increasing their risk for contracting HIV. Furthermore, sexual minorities have been found to experience high rates of violence, which may impact future risk behaviors.

Invisibility

The risk of female-to-female transmission is very low. However, one should also examine the external factors that may woman's sexual and risk behaviors. Consider the woman who comes from a strong culturally conservative religious background who is forced to hide her sexual identity by passing as a heterosexual woman. This woman also has sex with men. Depending on the power dynamics and role of gender in the relationship, the woman may not advocate for the use of protective barriers during sex with her male partner. Negative religious messages about homosexuality often have an adverse effect on how women see themselves as valuable and deserving of protecting themselves against HIV and other STIs. As with heterosexual women, lesbians receive societal messages about what a woman should and should not do with her body. Often the message is that women don't have the right to exercise self-autonomy in their sexual relationships; whether they are heterosexual or otherwise. Consider also the women who are forced to exchange sex for resources in order to survive and those who feel void of social and emotional support and turn to drug use, or the woman who faces discrimination in public spaces, due not only to her sexual identity, but to sexism and racism.

Women who have sex with women are not prioritized in HIV prevention efforts, despite the fact that WSW have reported significantly high rates of infection and HIV risk behavior. The Centers Disease Control and Prevention (CDC) contribute to this invisibility of risk because there exists no category to classify transmission between women (Montcalm and Myer, 2000). When a woman has had a male sexual partner, she

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is epidemiologically classified as heterosexual, despite how many female sexual partners she may have or how she may identify sexually (Dworkin, 2005).

While the CDC acknowledges that there is a risk of female-to-female transmission due to vaginal and menstrual fluid exchange, there remain no confirmed cases of female-to-female transmission of HIV in their database (CDC, 2006). The CDC's fact sheet, "HIV/AIDS among Women Who Have Sex with Women", states that although there are no confirmed cases, female-to-female sexual transmission of HIV should still be considered as a possible risk. In more than 60% of the CDC's reported HIV cases in 2004, the physician did not ascertain whether or not the woman had same-sex contact. Failure to collect this pertinent information only contributes to the invisibility of women who have sex with women and their HIV risk and status (CDC, 2006).

Common myths about these women's sexuality, as well as gaps in research, contribute to the lack of visibility among lesbians and WSW in relation to HIV prevention, contraction and transmission. Typically, funding for research goes to those areas that are deemed to be higher risk populations, ignoring the need for further study in the area of WSW and HIV.

Implications

The Institute of Medicine's (IOM) report on lesbian health declared that more research was needed in the field of lesbian health issues. The reasons cited were: 1) To gain knowledge and improve the health status of lesbians, 2) to confirm beliefs and counter myths regarding health risks of lesbians, and 3) to identify the health areas of which lesbians are at the greatest risk (IOM, 2000). The inclusion of lesbians and women who have sex with women in data collection and analysis will help to combat the invisibility these women have confronted within previous research. The surveillance of infections reported among women who have sex with women has not been adequate. It is prudent to have data collection on this population to gain insight on the reality of the epidemic as well as the actual number of cases and modes of transmission. As data collection improves many disparities will become more evident.

Further study and resources must be dedicated to examining the various health disparities among this population. Certainly, more research and education is needed, specifically in regards to HIV transmission and contraction in women who have sex with women. This may involve a study on specific sexual practices and behaviors that WSW engages in. Women who have sex with women are infected with HIV, and in some cases, transmission has occurred when the only risk factor involved is an infected female partner. To be written off as a 'low-risk' group, not only has health implications for lesbians and WSW (as infections rise), but also policy and prevention implications. First, low-risk groups will receive less attention in the way of funding, media exposure,

education/outreach, medical staff training and health screening, thereby impacting the degree to which policies and standards are developed in evaluating and assessing the reality of this population's risk. Second, the stigma that some hold against people with HIV/AIDS (PWA) has the great potential to leak into the policy arena. One such example was highlighted by the research presented by Herek et al. (2003), which found that those individuals who supported name-based HIV reporting possessed negative feelings towards people who were HIV positive, and believed that the stigma related to AIDS was not a great concern. In contrast, those who felt anonymous reporting would better protect the privacy and safety of PWA thought AIDS stigma was a major concern.

While increasing support from mainstream research is crucial, there are other areas in which progress can be made. Training medical staff to recognize the needs of lesbians and WSW and to deliver health care in a culturally competent manner is another area to be addressed. Health professionals must be properly trained in gathering the HIV history of WSW, and should be careful not to use language that make assumptions about one's sexual identity and/or behavior (White, 1997). Questions void of heterosexist assumptions will encourage an open dialogue between provider and patient.

Stigma and bias certainly exist within the medical field regarding to same-sex practices as well as AIDS. A survey of medical students found that 25% thought homosexuality was immoral and felt negatively about interacting with this population; 9% thought homosexuality was a mental illness and 14% stated increased feelings of homophobia since the rise of AIDS (LA Gay & Lesbian Center, 2000). As an increased number of youth become sexually active and start to explore their sexual identities, it is prudent to ensure that school staff, including psychologists, social workers, counselors, and nurses, are effectively trained in the health factors and risks specific to those who partner with members of the same sex (Sawyer et al., 2006).

Education and outreach efforts would also help to address the misperceptions that many lesbians and WSW have about HIV infection and transmission. As previously evidenced, multiple studies have indicated that women who have sex with women believe that they are at little to no risk for HIV. This is likely due to the lack of health information available to this population. It has been documented that perceived personal risk and educational levels are predictors of barrier use (Montcalm, Myer 2000).

Conclusion

The fact that female-to-female transmission of HIV has not yet been documented by the CDC and is seemingly hard to achieve, leaves providers, HIV preventionists and women who have sex with women thinking HIV is not an issue for lesbians and WSW. A review of the recent literature and reflections on our own 17 years of experience with lesbians and WSW validates that some lesbians/WSW engage in high risk behaviors

that place them at risk for HIV transmission. Some WSW use injection drugs and may share needles and works. Some WSW have sex, or sexual histories, with HIV-positive men and/or injection drug users. Our observations in LAP suggest not only that that WSW of color (in New York City as well as nationally) experience a number of environmental adversities that drive risk and confound expectations based solely on their sexual orientation, but that the dialogue about lesbians and HIV, and the resultant programming and service options for lesbians has not advanced much in years.

Lesbians need and deserve tailored health interventions and better health outcomes. After revisiting the literature, we hypothesize that a more substantive examination of the intersections between sexual health, sexuality, identity and stigma in public health programming has the potential to yield both. Until lesbians and WSW are acknowledged more substantially funding, research initiatives, education, policy reform and cultural competency, women will continue to fall through the cracks. Many women who partner with women will continue to believe that the risk of HIV is not a concern. Furthermore, to dismiss the risk faced by lesbians and women who have sex with women — whether low, medium or high — promotes marginalization and invisibility, stunts access to care and breeds stigma associated with HIV and AIDS in the lesbian and WSW community.

GMHC's Perspective

GMHC fights to end the AIDS epidemic and uplift the lives of all affected.

Reflecting the New York City epidemic, GMHC serves an active client base with 23% women (nearly 3,000 clients in FY08). Approximately 14% of GMHC's female client base in 2008 identified as bisexual, gay or lesbian.

Founded in 1992, LAP confronts the HIV prevention and care needs of lesbians and women of color in NYC who have Sex with Women (WSW). In the last 17 years, the Lesbian AIDS Project has been the 'go-to' place for lesbians and WSW, The mission of the Lesbian AIDS Project is to challenge the invisibility of lesbians, bisexual women and other women who currently or previously partner with women in the HIV epidemic. LAP currently serves 85 women annually with regular services and activities.

At a time when no one wanted to talk about lesbians getting HIV or even being at-risk for HIV transmission, LAP was the singular voice for the community. LAP brought HIV out of the closet in the WSW community! Through the years, we have gained significant expertise in understanding and working with the interconnection of stigma, social and cultural vulnerability, self-esteem and identity as they relate to sexual risk-taking among WSW. Today, LAP is still a central hub for HIV information and support for women in the lesbian and WSW communities.

LAP is more than a program, it is a community where WSW are affirmed in their identity, learn to love, empower, and protect themselves, which directly has the potential to reduce their risk-taking behaviors. LAP support groups reduce isolation, build peer support, increase skills and coping strategies to address the life challenges faced by at-risk and HIV-positive WSW.

LAP is a program of the Women's Institute at GMHC. The specific goals of the Women's Institute are:

- Focus broad public attention on recognizing the increasing impact of HIV and AIDS on women, and on addressing the core inequalities that are driving this trajectory, such as poverty, gender-based violence, sexism and sexuality biases, stigma, literacy and lack of education;
- Support the development and broad promulgation of best-practice prevention and treatment modalities specifically designed for, and controlled by women;
- Empower women affected and infected by HIV and AIDS to protect themselves, to take charge of their futures, and to lead the way towards re-defining and responding to their needs and autonomy.

Credits and Acknowledgments

This report was written and researched by Avinder K. Deol and Alicia Heath-Toby, with editorial support from Kimberleigh J. Smith, MPA and Sean Cahill, PhD.

Avinder K. Deol is a Master's Candidate in the Health Advocacy Program at Sarah Lawrence College. She has interned with a number of organizations, including the Women's Institute and Lesbian AIDS Project at GMHC, MergerWatch, Raising Women's Voices, and Planned Parenthood, and was the Conference Coordinator for the National Women's Speak-Out for Health Reform in NYC. She received her Bachelor's from Cornell College in Women's Studies and Political Science, where she was a member of Women's Resource Group, Union of Progressive Students, LGBTQ Alliance group, and advocated for midwifery and home birth reform in the state of Iowa. At the time of this printing, Avinder Deol had received her degree.

Alicia Heath-Toby is the Program Coordinator of the Lesbian AIDS Project in the Women's Institute at Gay Men's Health Crisis. She brings to her position 15 years of social justice advocacy experience on behalf of disenfranchised communities impacted by HIV and AIDS — as advocate and program coordinator and a cleric in the faith-based community that supports and affirms LGBTIQ communities of color. After receiving her Bachelor of Arts Degree from Holy Cross College, she was fortunate to come in to contact with an organization on the cutting edge of HIV and AIDS, the Black Commission on AIDS. In 1998, she began working with Loving In Truth, an HIV prevention program of Liberation In Truth Unity Fellowship Church (LITUFC).

Currently she serves as Assistant Pastor of Liberation In Truth UFC, and serves as an Advisory Board member of LITUFC's Youth and Young Adult Initiative, True Colors. Years ago, Alicia and her wife Saundra, accepted the invitation to join Lambda Legal and six other New Jersey couples in the lawsuit, Lewis vs. Harris, a case seeking the right to marry for same-sex couples in the state of New Jersey. She and her wife of 20 years live in Newark, New Jersey, and are the proud grandparents of six.

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LAP would like to dedicate this paper to the lesbians and WSWs living with HIV, to our supporters who are caring for us and to the advocates for challenging the invisibility of lesbians and WSWs in the face of the HIV epidemic.

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About Gay Men's Health Crisis

Our Mission: GMHC fights to end the AIDS epidemic and uplift the lives of all affected.

Our Clients, Our Services: Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. GMHC serves one in every six persons diagnosed with AIDS in New York City. As the world's oldest AIDS service provider, GMHC helps over 15,000 men, women and children and their families each year. GMHC offers a wide range of comprehensive client services, including hot meals, benefits/entitlements advocacy, healthcare advocacy, case management, legal assistance, HIV counseling and testing, individual and group counseling services, prevention education, home-based support, and mental health services.

GMHC has been on the frontlines of the AIDS epidemic since it began, focused on the communities most threatened by HIV and expanding our service provision as the epidemic shifts and grows. The number of GMHC clients has increased by over 50% just since 2000. Our clients reflect the diversity of the HIV epidemic:

- 67% are people of color;
- 65% are gay, lesbian, bisexual;
- 23% are women; and
- Over 50% reside outside of Manhattan.

Additionally, approximately 27% of our clients are 50 years of age or older, while 19% of all new prevention clients are under 30. Of our total clients served we continue to see a larger proportion living in poverty – approximately 78% are living on an annual income of less than \$10,000, while 8% are either homeless or living in transitional housing.

Questions? Contact Alicia Heath-Toby, Coordinator for LAP, at (212) 367-1355 or the GMHC Hotline, at 1-800-243-7692.

